COVID-19 Vaccine Prioritization Guidance and Interim Allocation Framework

Washington State Department of Health

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RECORD OF CHANGES

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	1	**1/18/2021**	• Changed 1b tier 1 to age 65 and up instead of age 70 and up. • Clarified language based on public feedback • Proofreading edits	

EXECUTIVE SUMMARY

We are committed to providing a coronavirus vaccine to anyone who wants one in Washington State, and we will not have enough at first to offer it to everyone. This means we must make tough decisions about who gets the vaccine first. This is called vaccine allocation and prioritization. This document shares the Washington State Department of Health's guidance on this process. Given current information and federal guidance, we are providing guidance on Phase 1a and 1b with tentative future phases that will be updated based on:

- Vaccine supply and uptake
- New information from clinical trials and local data
- New federal guidance and vaccine recommendations
- Ongoing feedback from impacted communities, partners, sectors, and industries

Our Commitment

The Department of Health is committed to a safe and effective vaccine, transparency in our decisions, and leading with equitable allocation of the vaccines.

1. We will only distribute a vaccine that is demonstrated to be safe and effective in clinical trials, and will be transparent in sharing information on what is known about the benefits and risks of the vaccine.
2. We will only distribute the vaccine to groups for whom the vaccine is approved or recommended.
3. We will prioritize people, communities, and groups that are at higher risk for COVID-19 following the federal Advisory Committee on Immunization Practices (ACIP) recommendations.
4. We hear and are taking into account the concerns some people and communities have.

Framework Process Overview

We consulted experts on COVID-19 and engaged communities who have been disproportionately impacted by COVID-19, including communities of color, refugees, immigrants, farmworkers, people with disabilities, people experiencing homelessness, and people with underlying health conditions. We conducted 90 interviews and focus groups with 568 people across the state and received 18,000 responses to a survey available in multiple languages. In commitment to our Government-to-Government relationship with Tribal Nations, we have a separate and specific plan for engaging Tribal Nations and American Indian/Alaska Native communities.

Community Engagement Findings

The following themes emerged across all engagement efforts to date. Please visit the COVID-19 Vaccine Engagement webpage for more information and the full report.

Understanding COVID-19 Risks

1. Older adults are at risk due to their work, where they live, family gatherings, or cultural shared spaces
2. Those who face barriers to health care or quality health care are at risk
3. People with underlying health conditions are at risk
4. People who live in congregate living situations or in multi-generational homes are at greater risk
5. People who are exposed to others and/or the general public at work and/or in work settings where proper protocols are not taken are at greater risk

Disproportionate impacts: Many interconnected layers

1. COVID-19 affects many individuals within families and between families

2. Impacts reach people in their homes
3. Impacts happen in the workplace
4. The social safety net is necessary to catch people but it, too, is damaged by COVID-19
5. The "wellness" of low-income people and POC is already fragile and the fragility is further exacerbated by COVID-19
6. COVID-19 requires health resources that are not easily accessible to many communities especially when the demand increases exponentially

COVID-19 prevention

1. Difficult to follow COVID-19 preventative behaviors without adequate support and enforcement

Misinformation and Distrust

1. Vaccine hesitancy due to historical trauma and mistrust of government agencies and health care entities
2. Community trust is impacted by misinformation related to how the COVID-19 vaccine is being managed/manipulated by the government
3. Many people rely on digital media for information whether or not the digital information sources are accurate or factual
4. There are a lot of conspiracy theories and misinformation regarding the COVID 19 vaccine and any developments of a vaccine.
5. Those who are unable to access timely, accurate information or only see misinformation and disinformation are at risk.

Fears about the vaccine: safety, development, efficacy, logistics

1. There are many different concerns and fears about the COVID-19 vaccine.
2. Most cited fears clustered around safety and efficacy
3. Concerns about the process of development, the quality/rigor of the science, and the challenges of conquering a mutating virus formed the foundation of many fears.
4. Fears are exacerbated by a perceived lack of transparency, lingering questions and silencing of scientists.

Vaccine prioritization

1. There is support for prioritizing high-risk workers in health care settings, but we also need to intentionally define a high-risk role or environment.
2. Prioritization for key groups including farmworkers, elders, people with disabilities, and communities of color should be stronger.
3. Many essential services sectors feel left out and under-prioritized.
4. There is overall support for the National Academies of Medicine Equitable COVID-19 Allocation Frameworks' principles, criteria, and equity considerations.

Motivation to get the vaccine

1. Vaccination is an essential part to assist in returning to a resemblance of normal.
2. The social emotional and mental health aspects of a vaccine are high motivations for vaccine acceptance.

Communications, engagement, and outreach activities

1. Community engagement needs to start early and be done with trusted members in the community.
2. People want culturally and linguistically appropriate information.
3. Communities trust people and organizations that look like them and have a reputation of community care.

4. Communities also rely on public leaders, scientists and institutions when they speak directly, clearly, and apolitically.
5. Consider access needs and formats for all COVID-19 communications.
6. Ensure all public health, healthcare, and vaccine providers have the same communications resources.
7. Communication efforts should focus on transparency and building trust as a central goal.

Equitable distribution

1. Need to proactively address common health care access barriers experienced regularly by vulnerable communities; same barriers will impact vaccine access.
2. Two dose series and refrigeration requirements may create challenges for serving some communities.
3. Set up vaccine clinics in places that are safe, familiar, and accessible.

We incorporated the input of these experts and community partners into our guidance on Phase 1a and Phase 1b and the rest of the interim framework. As future phases are finalized, we commit to continue an inclusive, transparent, fair, and evidence-based process.

COVID-19 Vaccine Equitable Allocation Framework

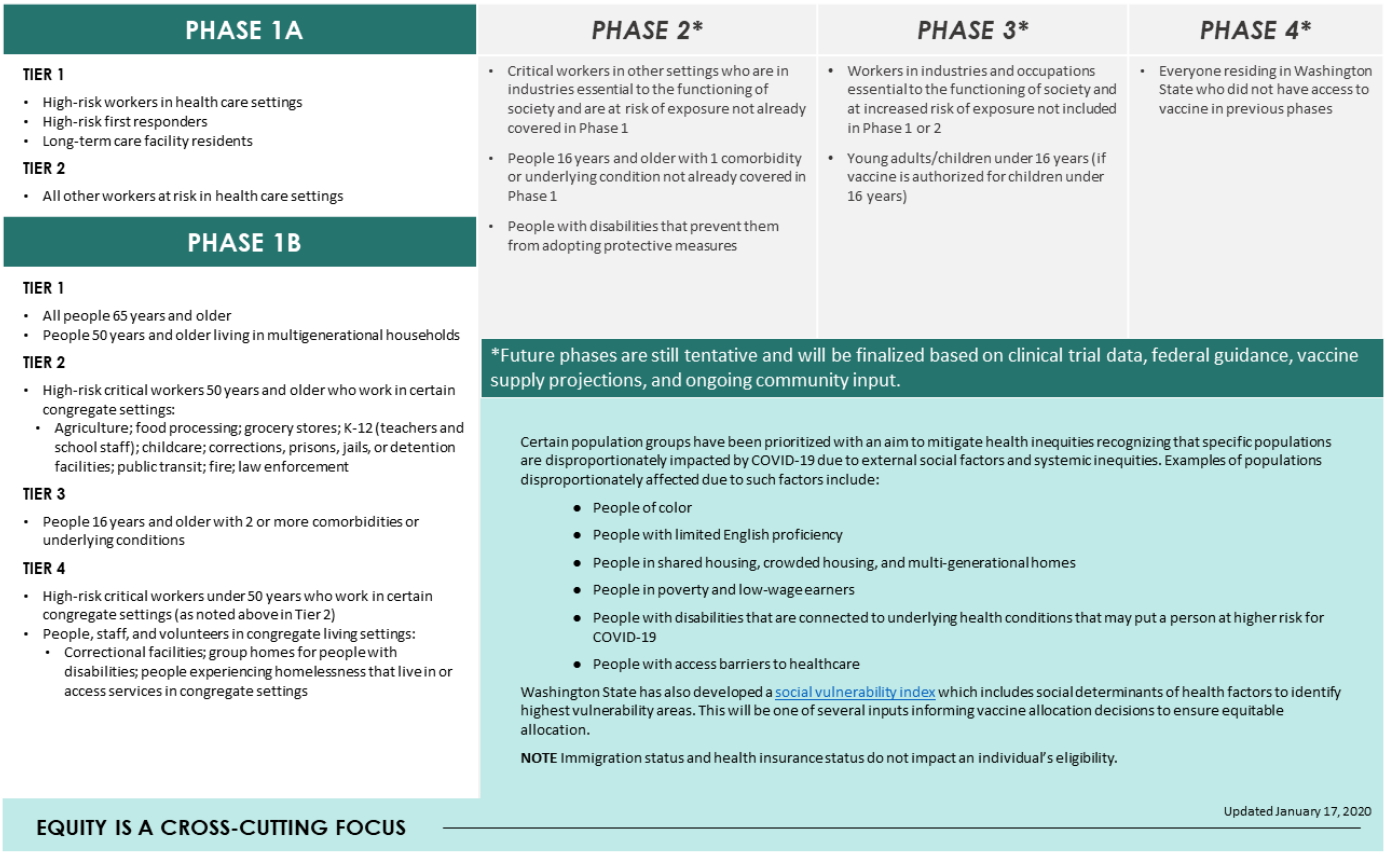
We developed our interim framework using a review of existing evidence and research and extensive feedback from disproportionately impacted communities, groups, and partners.

GOAL: To reduce severe morbidity and mortality and negative societal impact due to the transmission of SARS-CoV-2

ETHICAL PRINCIPLES
- Maximum benefit
- Equal concern
- Mitigation of health inequities

PROCEDURAL PRINCIPLES
- Fairness
- Transparency
- Evidence-based

CRITERIA
- Risk of acquiring infection
- Risk of severe morbidity and mortality
- Risk of negative societal impact
- Risk of transmitting infection to others



Implementation & Conclusion

Our guidance and interim framework is a step to facilitate a smooth, safe, equitable and effective vaccine distribution process across Washington state. We will coordinate with the federal government, providers, and other partners and community organizations and update as needed and communicate clearly and transparently. For up to date information about the COVID-19 vaccine, visit https://www.doh.wa.gov/Emergencies/COVID19/Vaccine.

INTRODUCTION

A COVID-19 vaccine is one of many tools and strategies that will help us manage COVID-19 in Washington state. The Washington State Department of Health (DOH) is committed to safe, equitable, and effective application of the vaccine and other tools. Current federal guidance indicates that there will be a limited supply of any vaccine deemed safe and efficacious enough for distribution. As a result, DOH began developing a framework for the prioritization and allocation of the limited vaccine. This document explains the development process and outlines our guidance and interim framework on equitable vaccine allocation to all people residing in Washington state.

DOH started with the National Academy of Science, Engineering and Medicine's Equitable Allocation for COVID-19 vaccine as a framework to gather input. Then, we engaged communities, groups, partners, and workers in sectors who are most disproportionately impacted by and concerned about COVID-19. The outreach therefore included communities facing underlying systemic factors like racism and other forms of oppression.

Our COVID-19 Vaccine Prioritization Guidance and Interim Allocation Framework will be updated and adapted over time. At a minimum, this guidance will be reviewed and potentially updated as a result of:

- More comprehensive and formal engagement with Tribal Nations and American Indian/Alaska Native communities
- Recommendations from the Centers for Disease Control and Prevention (CDC) and their Advisory Committee on Immunization Practices (ACIP)
- Local information regarding transmission, changes in the epidemic, and/or changes in the socio-economic context related to reopening plans
- More information released about possible vaccines, such as:
    - safety and effectiveness of the vaccine is for all populations
    - type of vaccines, dosing, storage, and administration requirements
    - number of doses available
    - when the vaccine will be released

Information about COVID-19 and potential vaccines continues to shift and evolve. We appreciate your patience and understanding as we plan for the COVID-19 vaccine, and we commit to sharing information and updated versions of this guidance.

Our Commitment

The Department of Health is committed to a safe and effective vaccine, transparency in our decisions, and leading with equitable allocation of the vaccines.

1. **We will only distribute a vaccine that is demonstrated to be safe and effective in clinical trials**, and will be transparent in sharing information on what is known about the benefits and risks of the vaccine**.** Washington State has joined four other states (California, Nevada, Oregon, and Colorado) to conduct an independent review of the safety and efficacy of any vaccine approved by the Food and Drug Administration (FDA) for distribution.
2. **We will only distribute the vaccine to groups for whom the vaccine is approved or recommended.** Clinical trials are still underway, and these trials will tell us for which populations groups the vaccine is demonstrating safety and efficacy.
3. **We will prioritize people, communities, and groups that are at higher risk for COVID-19 following closely the Advisory Committee on Immunization Practices (ACIP) recommendations.** We recognize this pandemic has not impacted communities equally, and that there are inequities in what protective

resources, like personal protective equipment, some communities have access to. We will lead with equity in our prioritization.

4. **We hear the concerns some people and communities have.** We will provide transparent, timely, and accessible information so communities can make informed decisions about their health.

Tribal Nations and American Indian/Alaska Native Engagement Plan

We honor the sovereignty and treaty rights of tribes, and we are committed to upholding our responsibilities described in Chapter 43.376 RCW (Government-to-Government Relationships) and engage tribes and Indian Health Care Providers through established channels.

The DOH Tribal Relations Director organized a Tribal Roundtable on October 27, 2020, which provided an initial opportunity for the COVID-19 vaccine planning team to provide updates on current progress and ask for input on how to engage tribes and Urban Indian Health Programs on COVID-19 vaccine topics and decisions moving forward. The COVID-19 vaccine planning team will continue using our established channels to collaborate and consult with Tribal Nations and engage Urban Indian Health Programs. This includes additional tribal roundtables and attending DOH/HCA Monthly Tribal Meetings to share information and continue COVID-19 vaccine related discussions. In addition, the COVID-19 vaccine engagement team will work closely with the DOH Tribal Relations Director to plan and carry out culturally appropriate engagement with tribal organizations and urban Indian organizations.

COVID-19 AND HEALTH EQUITY CONSIDERATIONS

The COVID-19 pandemic has shed light on existing health inequities, amplified them, and revealed their root causes. The inequities in cases, hospitalizations, and deaths, among other telling metrics, are the result of broader societal and structural factors like racism and other forms of oppression. These structural factors result in differential access to resources, services, and opportunities, including access to health care.

Inequities can be exacerbated or alleviated by intersecting identities. For example, recent research has shown that nurses of color are more likely to die from COVID-19 than their white counterparts. While occupation data is not available for all COVID-19 deaths, available data showed that registered nurses accounted for 30 percent of COVID-related deaths among health care workers nationally. Approximately 24 percent of registered nurses in the United States are individuals of color, but people of color accounted for 58 percent of deaths from COVID-19 among registered nurses. By comparison, 75 percent of registered nurses are white and accounted for 40 percent of deaths. Another study showed more broadly that health care providers with COVID-19 who died tended to be older, male, Asian, Black, and have an underlying medical condition when compared with health care providers who did not die.

This section highlights and explains these disparities as well as how they guided our value of **Equity as a Cross-Cutting Focus** in creating the interim phased plan.

Disparities in Cases, Hospitalizations, and Deaths

There are stark differences in COVID-19 cases, hospitalizations, and deaths for certain communities. The disparities we see in exposure and illness are also impacting many of the same historically marginalized groups that experience other health inequities. This is true at the state level and the national level (see **Appendix A** for key national data on the impact of COVID-19 on certain populations from the National Academies). There are other communities that experience inequities related to COVID-19 that are not well captured in our data systems,

for example people with disabilities. Additionally, a lack of disaggregation for large groups, for example by race/ethnicity, can mask differences in outcomes at a sub-population level.

The Department of Health's COVID-19 morbidity and mortality by race, ethnicity and spoken language in Washington state report, COVID-19 Confirmed Cases by Industry Sector and current data dashboard further details the disparities that do appear within currently available data. The Department of Health acknowledges these limitations and is actively working to promote data equity and address the systemic and technical challenges to more representative data collection systems. The following data are provided by the Washington State Department of Health.

Confirmed Case Rates

In terms of age-adjusted confirmed or probable case rates:

- Native Hawaiian and Other Pacific Islander (NHOPI) and Hispanic populations have the highest rates, while white and Asian people have the lowest.
- NHOPI and Hispanic populations have approximately five times higher rates than Asian and white populations.
- Black populations have approximately two times higher rates Asian and white populations.
- American Indian/Alaska Native people account for 2 percent of COVID-19 cases but only 1 percent of the total population.

Table 4. Percentages of confirmed COVID-19 cases hospitalized by primary language spoken

Language	Cases	Hospitalizations	Percent language specific hospitalizations
English	72,584	4,342	6%
Spanish	18,305	1,042	5.7%
Marshallese	311	48	15.4%
Vietnamese	526	53	10.1%
Russian	789	149	18.9%
Chinese (all)	140	24	17.1%
Ukrainian	201	54	26.9%
Somali	242	15	6.2%
Tagalog	100	22	22%
Amharic	108	12	11.1%
Other	1,348	160	11.9%

Employment data also shows disparities in COVID-19 cases among certain industries. In a report published on November 10, 2020, lab-confirmed cases of COVID-19 among residents reported through 11:59 PM on September 13, 2020 showed:

- People in the **health care and social assistance** industry sector account for 25 percent of COVID-19 cases even though only 13 percent of Washington's employed population is employed in this sector.
- People in the **agriculture, forestry, fishing and hunting** industry sector account for 11 percent of COVID-19 cases even though only 3 percent of Washington's employed population is employed in this sector.

Hospitalization Rates among Confirmed Cases

Among confirmed or probable COVID-19 cases:

- Native Hawaiian and Other Pacific Islander (NHOPI) populations have the highest hospitalization rates and white populations have the lowest. NHOPI hospitalization rates are eleven times higher than white populations.
- Hispanic populations hospitalization rates are six times higher than white populations.
- Black and American Indian and Alaska Native populations have hospitalization rates that are three times higher than whites.
- Certain language groups have hospitalization rates that suggest increased exposures and/or barriers to care may contribute to more severe disease. (See **Table 4**.)
- American Indian and Alaska Native people account for 2 percent of COVID-19 hospitalizations but only 1 percent of the total population.

Death Rates among Confirmed Cases

Among confirmed COVID-19 cases:

- White populations have the lowest death rates of all race/ethnicity groups when stratified by age.
- Native Hawaiian and Other Pacific Islander populations have death rates are six times higher than whites.
- American Indian and Alaska Native (AI/AN) and Hispanic populations have death rates that are four times higher than whites.
- Black populations have death rates that are about twice as high as white populations.
- AI/AN people account for 3 percent of total COVID-19 deaths but only 1 percent of the population.

Causes of Health Inequities in COVID-19 Health Outcomes

Adverse health outcomes from COVID-19 come not only from the virus itself, but also from the unintended consequences of the Washington state government's mandates and initiatives to contain it. Again, these impacts are felt most by those who are historically and currently marginalized.

Access Barriers

Many communities experience barriers to accessing critical health information and services due to race/ethnicity, language, culture, nationality, immigration status, or disability status. Structural, institutional, financial, social, cultural, and sociodemographic factors impact their access both now and historically.

Types of access barriers include:

- **Economic barriers** such as insurance status and cost of care.
- **Structural barriers** such as limited or no transportation; work, school, or childcare limiting someone's time and availability; lack of culturally and linguistically appropriate services; inaccessible clinic environment and conditions; lack of access to broadband.
- **Social barriers** include differential treatment by providers; experience of discrimination; health literacy; and historical trauma.

Employment Conditions

Many employment-related factors can impact worker health. Depending on their jobs, workers face increased risk of exposure to COVID-19, lost jobs or income due to unintended consequences of COVID-19 restrictions, or workplaces where they are unable to socially distance or are not provided personal protective equipment.

EXAMPLE Low-income workers are less likely to be able to socially distance while at work or to work remotely. People of color are more likely to work in service industries, such as restaurants, retail, and hospitality, which puts them at higher risk for loss of income during the pandemic. Also, people of color are more often working jobs that are not amenable to teleworking and they more often use public transportation that puts them at risk for exposure to COVID-19 (SAMHSA, 2020; Benfer, E. & Wiley, L., 2020; and Artiga, S., Garfield, R., & Orgera, K., 2020).

Housing

Individuals experiencing homelessness and individuals living in shared or transitional housing are at increased risk for exposure. In addition, stay-at-home orders or other COVID-19 response initiatives have unintended consequences on the health and well-being of survivors of domestic violence.

EXAMPLE People of color are more likely to live in multigenerational family co-housing and low-income and public housing. These situations make it difficult to social distance, quarantine, or self-isolate (SAMHSA, 2020; Benfer, E. & Wiley, L., 2020; and Artiga, S., Garfield, R., & Orgera, K., 2020). Also, individuals experiencing homelessness may be at particular risk of COVID-19 due to their mobility (it is difficult to track and prevent transmission); lack of access to hygiene supplies; limited access to health care; lack of a medical home; and limited access to public spaces as a result of shutdowns.

Other Unintended Consequences

The Washington state government has worked to prevent the spread of COVID-19 through travel bans, social distancing measures, and isolation and quarantine protocols. In addition, COVID-19 cases have brought increased strain on the health care system. People who are likely to experience the unintended health consequences of these factors include, but are not limited to, pregnant people; people with unrelated acute, severe, or chronic health conditions; people of color; and individuals with disabilities.

EXAMPLE Sixty-one percent of Black adults and 60 percent of Hispanic adults reported that the COVID-19 pandemic has impacted their mental health, in comparison with 55 percent of white adults.

Equity as a Cross-Cutting Factor

As illustrated in the previous sections, the root causes of differences in COVID-19 cases, hospitalizations, and deaths are due to long-standing systemic inequities; as are the differences in access to COVID-19 information, services, and treatment in culturally and linguistically responsive ways. As a result, Washington state is intentionally taking a pro-equity approach to COVID-19 vaccine prioritization and allocation.

We have focused on the following groups as cross-cutting all phases of our prioritization and allocation framework. The focus on these cross-cutting groups were well supported by the impacted communities, partners, groups, and sectors who participated in our engagement and public feedback opportunities.

People with access barriers to health care: People with limited transportation, people with limited English proficiency, individuals with disabilities, people without health insurance, undocumented people

People at higher risk for exposure: Farm and factory workers, essential workers, people who live in congregate housing, people experiencing

People who have been disproportionately impacted by COVID-19 because of systemic inequities: Communities of color, people with limited English proficiency, individuals with disabilities, low-income people

People at risk for severe illness: Older adults and elders, pregnant people, people with underlying

homelessness, people who are incarcerated or detained, people in workplaces with outbreaks

People essential to health and wellbeing of populations at higher risk: Doulas, caregivers (both formal and informal), home care aides, health care interpreters, community and mutual aid volunteers, community health workers

medical conditions that put them at a higher risk for severe morbidity or mortality if infected with COVID-19

People who are at higher risk for spreading COVID-19 to high risk populations: Caregivers, people living in multi-generational households, children and youth, essential workers, people who must travel for work

People who live in areas with greater spread: Geographic hotspots and outbreaks, congregate housing with outbreaks

GUIDANCE DEVELOPMENT PROCESS

To develop our COVID-19 vaccine prioritization guidance and allocation framework, we emphasized proactive community engagement, transparency, evidence, and fairness. First, we reviewed content from several sources including the CDC's Advisory Committee on Immunization Practices (ACIP), the World Health Organization, Johns Hopkins Center for Security, and the National Academies of Sciences, Engineering, and Medicine. Since we knew ACIP guidance would not be available until later, we began with the National Academies' Framework for Equitable Allocation of COVID-19 Vaccine to gather initial feedback and initiate planning.

Community Engagement Methods

Focused Engagement Approach

To hear from communities most impacted by COVID-19 about the prioritization and allocation framework, we used a mixed methods approach and conducted 90 separate interviews, group interviews, focus groups, and community conversations. These were conducted primarily by phone and video chat with 568 individuals across the state over a three-week period in October 2020.

The Department of Health's internal COVID-19 Community Engagement Task Force led these efforts and partnered with several of the existing Emergency Language and Community Outreach Services contractors statewide to carry out additional culturally appropriate community engagement efforts within their own communities. The information gathered through these activities was also supplemented by advocacy letters from disproportionately impacted businesses and other sectors, as well as by qualitative open-ended responses to survey questions. See **Appendix F** for all question sets.

We engaged community members, partners, and representatives and asked participants to self-identify the communities they belong to and/or represent. Most often, people self-identified with more than one community. Over the course of all focused engagement efforts, we identified representation from the following communities, groups, and sectors (**Table 3**).

Participants identified as being connected with 28 counties or said they were connected statewide (**Table 4**). Being connected to a county includes the county that a participant lives in as well as the county or counties a participant works in. We did not focus our engagement efforts on geographic communities, however, we do have the ability identify any geographic-specific feedback.

Table 3: Community engagement group representation

Disproportionately Impacted Communities[1]	Essential Sectors, Services Sectors, and Industries	Health Care and Public Health Partners	Other High Priority Communities, Groups, and Sectors

Black/African American community
Asian/Asian American community
Native American
Native Hawaiian and other Pacific Islanders community
  Marshallese, Micronesian, and COFA (Compact of Free Association) communities
Latinx community
Immigrant and refugee communities
Asian diaspora
African diaspora
Latin American diaspora
Former Soviet Union (FSU) diaspora
Undocumented communities
People with underlying health conditions
Older adults
Pregnant people
Individuals with disabilities
People experiencing homelessness
People who are incarcerated
Low-income communities
Uninsured communities
	Essential and front-line workers
	Agricultural sector
	  Migrant workers
	  Farmworkers
	  Seafood industry
	Food bank services
	Business community
	Public transportation
	Hospitality industry
	Public utilities
	Parks and recreation
	Technology sector
		Local Health Jurisdictions
		Community health clinics
		Community Health Workers and promotoras
		Behavioral health and substance use disorder services
		Community blood centers
		Rural medical services
		Pharmacy
		Post-acute and Long-Term Care
		Veterinary care
			Children with special health care needs
			Youth
			Youth in foster care
			College and university students
			Parents
			Early learning and early childhood
			LGBTQ+ community
			Rural communities
			Border communities
			Sub-urban communities
			Faith-based communities
			Veterans
			Women

[1] Communities that have experienced the greatest COVID-19 inequities related to cases, hospitalizations, deaths, and risk of severe illness. Participants self-identified as being in these groups and were often in more than one group.

Table 4: Community engagement counties

All (statewide)	Ferry	Kitsap	Pend Oreille*	Thurston*	*Focused engagement efforts
Adams	Franklin*	Kittitas*	Pierce*	Wahkiakum	
Asotin*	Garfield	Klickitat*	San Juan*	Walla Walla*	
Benton*	Grant*	Lewis*	Skagit*	Whatcom*	
Clallam*	Grays Harbor*	Lincoln	Skamania*	Whitman	
Clark*	Island*	Mason*	Snohomish*	Yakima*	
Cowlitz*	Jefferson*	Okanagan*	Spokane*		
Douglas	King*	Pacific*	Stevens		

Focused Engagement Analysis

For all activities, either a designated note taker or the facilitator took notes. As needed, all engagement activities were facilitated in-language or with the assistance of an interpreter or Communication Action Real-time Transcription (CART) services. We redacted all participant names, saved all transcripts as text documents, and then uploaded into Dedoose (version 8.3.35). A contractor analyzed qualitative data using thematic analysis. The codebook was developed iteratively and derived from assessment goals, data, and the prioritization framework. Each transcript was coded individually, and the codebook was adapted as necessary. Each code report was summarized into a table of theme domains and subdomains with associated quotes.

Broad Engagement Approach

We also collected feedback from the broader public through a web-based survey (see **Appendix F** for survey questions and full results). This survey was provided in the following languages (see **Table 5**) and disseminated through existing partner channels, Department of Health (DOH) listservs, the DOH website, and social media accounts. We selected these languages because they are common in Washington state and we have had success reaching people who speak them through other web-based communications during the pandemic.

Table 5: Survey respondents by language

Language	Number of Respondents
English	17,678
Spanish	70
Vietnamese	36
Chinese (simplified)	36
Chinese (traditional)	160
Russian	29
Ukrainian	12
Tagalog	2

The survey was split into three parts: 1. How are you feeling about COVID-19?; 2. How should we decide who gets the vaccine first?; and 3. Tell us about yourself (optional). In addition to analyzing the overall survey results **(Appendix F)**, we also filtered and analyzed the results by the respondent's area of work and whether they identified as someone at increased risk for COVID-19 because of their race/ethnicity, disability status, or overall health and age.

Our analysis included all in-language surveys that had at least 10 respondents. These survey results supplement what we learned through the qualitative, focused engagement efforts with these respective communities. We also collected information about the specific county respondents reside in and will provide those county-specific reports of the results to our local health jurisdiction partners.

SELECT ENGAGEMENT FINDINGS

Main themes related to vaccine prioritization and allocation

The following themes are the preliminary findings related to vaccine prioritization and allocation that emerged across all engagement activities including interviews, focus groups, community conversations, and surveys. This is a small selection of the overall engagement findings. Please visit the COVID-19 Vaccine Engagement webpage for

more information and the full report. Additionally, we are planning future waves of engagement with other impacted groups, sectors, and industries and will continue to publish all results online.

UNDERSTANDING COVID-19 RISKS

1. Older Adults are at risk due to their work, where they live, family gatherings, or cultural shared spaces

- Older adults who live in intergenerational homes, multi-family housing, nursing homes or other congregate care settings, jails, and homeless shelters are at higher risk for exposure, as are older adults who receive assistance from their family or neighbors.
- Some older adults have occupations that may put them at increased risk, including fishing boat managers (also likely to be black, indigenous, or people of color), teachers, utility and water operators, and other occupations where they can't make choices about the safety of their jobs. Those in working class jobs are unable to reduce their workplace risk and are too reliant on income from those positions to leave or stay home even when isolation is warranted.

"Being part of the Asian community, we put a lot of resources and respect toward our elders. My concern is really toward my grandparents and other members that I really think of as staples of our community."

2. Those who face barriers to health care or quality health care are at risk

- The Latinx community, including farmworkers and those working at food processing plants, may be uninsured or underinsured. In addition, fear of losing their job, the cost of tests and treatment, and worries about their status (if they are undocumented), are likely to prevent them from seeking care.
- Rural communities often face delays in getting care and those without transportation cannot access care.
- Low-wage workers without health insurance often do not access health care. In addition, low-wage workers may not seek care because they would become food insecure if they miss work.
- Communities of color have limited access to testing, may be homebound with limited access, and have comorbidities that are a direct result of health care they have received. Native Americans struggle to get health care.
- Transgender and homeless queer youth may not have access to health care.

"[Farmworkers] are going to go to work or die."

3. People with underlying health conditions are at risk

- Latinx, Indigenous, Black people, other communities of color, and immigrants and refugees often have underlying conditions, such as diabetes, cancer, asthma, or other pulmonary conditions as well as higher health disparities overall due largely to systemic oppression.
- Medically fragile children are at greater risk as are children with disabilities.
- People with disabilities may have multiple health conditions, rely on home health workers, and have marginalized immune systems.
- Older people are more likely to have heart disease, diabetes, COPD, and compromised immune systems that put them at greater risk.

- Those with mental illnesses, especially those who are homeless, may be more likely to congregate together or spread COVID-19 without knowing it.

4. People who live in congregate living situations or in multi-generational homes are at greater risk

- Workers who live where they work, such as farmworkers, fish processors, and rural utility district work site employees are at greater risk. They live in shared quarters with shared bathrooms with other workers. Many sleep in bunk beds that are not socially distanced.
- Black people, Indigenous communities, and other communities of color, including immigrants and refugees, reported that they often live close to one another, with multiple generations in one household.
- The high cost of living also forces low-wage workers across the spectrum to live in overcrowded or dense housing situations. Families living in low quality housing have underlying respiratory diseases, which are exacerbated by stay-at-home orders. Low-wage workers are also likely to rely on public transportation, further exposing them to the virus.
- People experiencing homelessness, especially homeless queer youth, are at particular risk. Those who are transient, may not able to test/treat/isolate; for those who do want to access shelter beds, the number of beds is reduced due to an effort to separate people for social distancing.
- People with disabilities, older adults, and staff in congregate care living settings, are at higher risk especially if the setting employs shift staff who are at high risk themselves. In addition, isolating people in long-term care facilities is detrimental to their mental health.
- People who are incarcerated cannot be isolated and do not have options to isolate themselves.
- University students living in congregate housing are at risk. Students have higher social and mental health needs for personal contact and may take more risks.

"Agricultural workers living in cabins: They have 40 people to 2 bathrooms."

"Bunk beds are not social distancing."

5. People who are exposed to others and/or the general public at work and/or in work settings where proper protocols are not taken are at greater risk

- People working in jails and prisons, health workers, front line workers, pharmacists, restaurant and grocery workers, utility workers, critical infrastructure workers, contact tracing professionals, public transport workers, volunteer firefighters, people who work in hospitals, parks and recreation staff, hatchery staff, long-term care workers, farmworkers, sex workers, veterinarians and veterinary staff are at increased risk. Child care workers, school staff and nurses, teachers, and workers who leave their children in congregate child care, and other workers that are exposed to people or work in settings where proper safety precautions aren't taken are at high risk.
- People who work in food processing may work in spaces that are closed, spaces that do not adapt well to social distancing, or where installing separation barriers would create barriers to safety. In these settings where spread occurred, 75 percent or more of the crew were infected. Farmworkers are at risk on buses that bring them to the field and in their sleeping accommodations.

- Black and brown communities, including immigrants and refugees, are highly represented in jobs that are at higher risk because of exposure to others. Or the workplaces don't have enough safety protocols in place or are the last to receive PPE. Examples include: farmworkers and food processors (as stated above), dairy workers, meat packing plant workers, public transportation workers, housekeepers, nail salon workers, fishery staff, community-based organization staff who meet with clients, home health care workers, grocery store staff, community workers who go with clients to their appointments, Uber or Lyft drivers, retail industry workers, and health workers. In addition, older adults in these communities often work in high exposure jobs.
- Sex workers are at risk when seeing clients, which disproportionately impacts queer and trans Black, Indigenous, and other people of color.
- Low-wage workers often need to work to support their families and work multiple high-risk jobs where their attendance is critical to support others impacted by COVID. This may include working in service jobs in community based organizations such as homeless shelters. People with disabilities often work in lower-paying jobs as home health workers, in grocery stores, and in restaurants where they have higher risk of encountering people with COVID-19. Students who work in retail or at restaurants may need their salaries but their workplaces may not protect them. In addition, low-wage workers often take public transportation and don't have funds to purchase their own PPE.

"I got infected at work in the cafeteria. People would take off their mask to eat and leave the mask on the table. If you arrived at that table after that person and did the same, right there you caught the virus."

"I was infected at work. In our work place there was not enough disinfection. They didn't give us gloves or masks and it is very easy to get infected."

"Our crews [fishery crews] are a pretty diverse group the higher up the managerial people tend to be older and are approaching high-risk for their health. We also have minority populations our company in particular employs Asian and Pacific Islanders. Some other are Somali Americans. That should be considered when you think about the category of risk."

DISPROPORTIONATE IMPACTS: MANY INTERCONNECTED LAYERS

1. COVID-19 affects many individuals within families and between families

- Children: Children in much of Washington have been unable to return to in-person schooling. The safety nets provided at school (teacher attention, school nurse, special education aides) are either absent or seriously overwhelmed in the online environment. For low income, rural, LEP, disabled and low tech students, online schooling is very challenging if not impossible. Children are experiencing loss of housing, hunger, postponement of well-child medical care and, in the most extreme cases, death of relatives and friends. Older children may be responsible for younger children's care. Children with special needs are especially impacted when they lose support services or have to care for themselves. Young adults: College and university students experience mental health impacts resulting from isolation, loss of job/pay covering the cost of education, assumption of family care for younger siblings, and many of the same impacts as their younger counterparts.
- Working age adults/parents: Adults are impacted by employment, housing, physical and mental health factors to varying degrees. Adults of color and low-income adults are particularly impacted as individuals,

parents and caregivers of older adults. Essential workers discover it is difficult to access child care when the adult becomes ill from COVID.

- Older adults: Seniors living in extended family homes are exposed to risk via their housing situation and in the case of low-income seniors via their workplace. This is particularly true for People of Color (POC), immigrants and disabled seniors. Older adults are particularly affected by the intersectionality of age, ethnicity, profession and poverty.

2. Impacts happen in the workplace

- Job-related impacts are felt most intensely by low-income workers. They often work in high-risk environments without the ability or autonomy to reduce their personal risk.
- The same elements of the workplace that increase risk for contracting COVID exacerbate the impact when one becomes sick with the disease and prevent individuals from quarantining at home:
    - Lack of health insurance or sick pay, low pay, necessity to purchase one's own PPE all keep sick people going to their job while sick or plunges them into poverty when medical crises hit.
    - Shift work, multiple low paying jobs, crowded workplaces and the inability to work from home increase COVID-related stress, financial insecurity and ongoing risk of exposure.

MISINFORMATION AND DISTRUST

1. Vaccine hesitancy due to historical trauma and mistrust of government agencies and health care entities

- There is an overwhelming distrust of federal and government agencies, health care systems and entities due to historical events and trauma (i.e. Tuskegee experiment). There is a long history of medical experimentation, harm and testing on Black communities, Indigenous communities, disability communities and communities of color as well as experiences of racism and discrimination within health care that contribute to mistrust.
- There is concern about safety and efficacy of a vaccine due to rapid development and lack of transparency about vaccine development.
- All groups expressed fear that BIPOC communities will be the first individuals vetted to take the vaccine and utilized as test subjects.
- There is collective agreement and support to partner with community representatives and community members for transparent vaccine information, communication, and distribution efforts.

"Generational trauma is huge in the Black and Brown community especially around vaccinations, around government testing, and around the government. There is no trust there."

"I am not willing to be the guinea pig for this government."

FEARS ABOUT THE VACCINE: SAFETY, DEVELOPMENT, EFFICACY, LOGISTICS

1. Most cited fears clustered around safety and efficacy

- People across all communities and groups have questions and concerns about the safety and efficacy of the vaccine.
- Fears about possible short- and long-term side effects from getting the vaccine were the predominant worry. For healthy people, side-effects were seen as creating an additional risk while for individuals with disabilities and underlying health conditions; vaccines were perceived as potentially making current problems worse.
- Efficacy, durability and reliability all caused respondents to express hesitation and concern.

"I think our community needs more education in regard to COVID vaccine from people from our community, especially about what harms it can have."

VACCINE PRIORITIZATION

1. There is support for prioritizing high-risk workers in health care settings, but we also need to intentionally define a high-risk role or environment.

- Not all health care environments and settings have the same access to personal protective equipment (PPE), and not all workers within a setting have equitable access to PPE.
- There are other people who work in high-risk health care settings and environments or with high-risk patients, beyond nurses and doctors. Community Health Workers (CHWs) and *promotoras*, doulas, janitorial staff, caregivers, and aides move through these settings too.
- More than 90 percent of all communities and groups who participated in the general feedback survey, interviews, or focus groups - across all language and cultural groups - agreed that high-risk health care workers should receive priority for the COVID-19 vaccine.

"Essential medical personnel need to save the rest of us, and if they get the shot, we will follow their example."

"I think medical people should be given the vaccine first, not just because of their risk, but because seeing doctors and scientists, maybe especially from communities of color, and even those in government getting the vaccine early will hopefully give the general public confidence that it is safe."

2. Prioritization for key groups including farmworkers, elders, people with disabilities, and communities of color should be stronger.

- Some groups received strong support for being a higher priority, including farm/agriculture (and H2-A-"guest") workers, people with disabilities, people experiencing homelessness, and elders.
- There is a need to think about the other individuals who surround high risk groups. Many farm/food processing workers are living in multi-generational households. People with disabilities may have caregivers that put them at risk.
- People who are incarcerated may have identities and risk factors that put them in a different phase of priority, such also having a disability or comorbidities. Also, we need to consider the potential of corrections staff getting sick.
- There is a need to think more broadly about "congregate settings." Agricultural workers living in cabins would fall under congregate settings. Individuals with disabilities may also be in congregate living situations.

"There is no real mention of race in this plan. It needs to be called out."

"Farmworkers and essential workers need to be at the top countered with the equity issues of how bodies of color have been used as test subjects in the past."

"Pacific Islanders are top highest infected more than any other group."

3. Many essential services sectors feel left out and under-prioritized.

- Certain groups are very concerned their frontline workers (or highly impacted people) won't be considered in the first round of vaccinations. Many groups expressed feelings of being left out, forgotten, not supported, or not considered.
- Non-profits, service, and volunteer organizations do not feel supported or considered as essential.
- There are critical infrastructure workers in almost every sector that have no alternatives if they get sick, and many could have long-term effects if their work goes undone. Everything from hatchery staff protecting and maintaining our food supply to data and cyber security teams to utility operators to foster care; so many of these workers feel like they haven't been considered essential.
- The hospitality industry has by far the highest number of individuals on unemployment in the state and nationally, and the long-term economic impact on these workers reaches all aspects of their wellness.

"Childcare, custodial, and maintenance workers should be moved up. They keep the community going, clean, safe."

4. There is overall support for the National Academies of Medicine Equitable COVID-19 Allocation Frameworks' principles, criteria, and equity considerations.

- The overwhelming majority of people who participated in all engagement activities including the public feedback survey, interviews, and focus groups—across all language and cultural groups—supported the inclusion of the working principles and criteria. The framework includes recommendations for equitable vaccine allocation.

"Generational trauma is huge in the Black and Brown community especially around vaccinations, around government testing, and around the government. There is no trust there."

INTERIM EQUITABLE FRAMEWORK OVERVIEW

In this section we outline our working principles, goal, criteria, and phases. It is important to note that these may change as the COVID-19 vaccine situation evolves.

Principles

Consistent with the National Academies approach, this guidance was developed keeping in mind six foundational principles described below. These principles are similar to those of other frameworks, such as the Advisory Committee on Immunization Practices (ACIP) and the World Health Organization. The overwhelming majority of people who participated in all engagement activities including the public feedback survey, interviews, and focus groups—across all language and cultural groups—supported the inclusion of these six principles.

Ethical Principles

- **Maximum benefit** encompasses the obligation to protect and promote the public's health and its socioeconomic well-being in the short and long term.
- **Equal concern** requires that every person be considered and treated as having equal dignity, worth, and value.
- **Mitigation of health inequities** includes the obligation to explicitly address the higher burden of COVID-19 experienced by populations affected most heavily, given their exposure and compounding health inequities.

Procedural Principles

- **Fairness** requires engagement with the public, particularly those most affected by the pandemic, and impartial decision making about and even-handed application of allocation criteria and priority categories.
- **Transparency** includes the obligation to communicate with the public openly, clearly, accurately, and straightforwardly about the allocation framework as it is being developed, deployed, and modified.
- **Evidence-based** expresses the requirement to base the allocation framework, including its goal, criteria, and phases, on the best available and constantly updated scientific information and data.

"I feel like the most important principles are equal regard and evidence-based research as everyone is at risk of this deadly virus. I am not sure exactly how you guys improve these principles more or less just ensure everyone is treated equally while also trying to reduce the sickness and deaths by COVID-19."

Goal

Guided by these principles, we have adopted the following overall goal: **To reduce severe morbidity and mortality and negative societal impact due to the transmission of SARS-CoV-2**.

Criteria

The framework leverages four risk-based criteria to set general priorities among population groups and to provide guidance that recognizes the heterogeneity of the populations. The overwhelming majority of people who participated in all engagement activities including the public feedback survey, interviews, and focus groups—across all language and cultural groups—supported the inclusion of these criteria. The four criteria are:

- **Risk of acquiring infection:** Individuals have higher priority to the extent that they have a greater probability of being in settings where SARS-CoV-2 is circulating and of being exposed to a sufficient dose of the virus.

- **Risk of severe morbidity and mortality:** Individuals have higher priority to the extent that they have a greater probability of severe disease or death if they acquire infection.
- **Risk of negative societal impact:** Individuals have higher priority to the extent that they serve a societal function (a role or need within society) and other individuals' lives and livelihood depend on them directly and would be imperiled if they fell ill.
- **Risk of transmitting infection to others:** Individuals have higher priority to the extent that there is a higher probability of their transmitting infection to others.

We are using existing data, studies, surveys, interviews, and focus groups with partners to assess different population groups against these risks. We will continue to monitor CDC updates related to these groups. We relied on this data, local data, and research summarized in the National Academies' publication (see **Appendix A**) to ensure our assessment and subsequent guidance were evidence-based and consistent with our principles. Our guidance was also informed by disproportionately impacted communities, groups, and partners. We are committed to continuing to review and gather input to adapt the guidance and framework over time.

Phases

Based on the feedback received from community partners and several Washington state COVID-19 expert groups including the Disaster Medical Advisory Committee, COVID-19 Vaccine Scientific Advisory Workgroup, and the Vaccine Advisory Committee (see **Appendix B** for participant lists), and federal guidance, our guidance provides greater specificity around sub-populations than the National Academies' equity framework. This additional specificity aims to help risk-stratify populations when vaccine supply is limited. Otherwise, the guidance remains consistent with the National Academies' equitable framework and Advisory Committee of Immunization Practices, with exceptions noted in each phase.

Given the principles, goal, and criteria, Washington state offers a four-phase approach to equitable COVID-19 vaccine allocation as outlined in "Allocation Guidance within Each Phase.**"** This guidance is based on the best available current evidence, but it cannot be emphasized enough that the dynamic nature of COVID-19 pandemic and the vaccine landscape means that this approach may need to be adapted over time.

It is also important to note that population groups overlap and there are individuals who fit into multiple categories. If this is the case for an individual, the higher phase should take precedence. Further, there is significant heterogeneity within each group and so the next section ("Applying the Framework for Equitable Allocation") provides further guidance to identify sub-populations that are at highest risk in terms of the criteria outlined in the previous section. Also, the order of the populations within a phase or tier does not suggest any type of prioritization or risk stratification.

APPLYING THE FRAMEWORK FOR EQUITABLE ALLOCATION

Statewide engagement confirmed broad support for a standardized approach to ensure a consistent and equitable allocation of COVID-19 vaccine across the state of Washington. As such, this section provides more detailed guidance regarding:

- Factors informing moving to from one phase to the next phase
- Prioritizing allocation of vaccines to different provider sites within a phase
- Prioritizing allocation of vaccines within populations

All of these are designed to ensure consistent application of the principles and criteria to achieve our shared goal.

Factors Informing Moving to a New Phase or Tier

If there is limited vaccine supply, DOH will utilize the equitable allocation framework to identify populations to prioritize. DOH will rely on four key factors to determine when it will announce moving to the next phase:

- **Vaccine coverage trends of prioritized populations** – assessing the vaccine coverage of currently prioritized populations (e.g., achieving 75% coverage) and the uptake trends to estimate projected demand; will also consider variation in time it will take for vaccine uptake in different populations
- **Vaccine supply** – how much vaccine is currently available in Washington; inventory trends
- **Vaccine projections** – how much vaccine supply is projected to arrive in Washington state in the coming months based on information provided by the federal government
- **Current scientific data** – current information related to vaccine efficacy and safety and epidemiological context

DOH will review this information to identify when projected supply will exceed expected uptake with prioritized populations to move to the next phase or tier.

Prioritizing within a Phase or Tier

When we enter each phase or tier, there will not be enough vaccines to cover all the prioritized population groups across all provider sites. DOH will make decisions about allocation to different provider sites across the state based on the following factors:

- Estimated size of prioritized populations in geographic areas to achieve proportional allocation
- Emerging data regarding vaccines – safety data or existence of clinical data of vaccine(s) with certain populations guiding eligibility
- Implementation issues if applicable – requisite cold chain capacity, ability of site to administer all vaccine doses before they expire, provider site willingness to vaccinate outside their own personnel or patients, provider site engagement with local health jurisdiction planning efforts, inventory information and trends, and interest to minimize changing the type/brand of vaccine
- Epidemic conditions – high transmission or outbreak settings
- Social vulnerability factors and equity impact

Regarding this last point, Washington state will apply a social vulnerability index to incorporate social vulnerability factors and equity in allocation decisions. The index uses variables at the census tract level, including socio-economic determinants (e.g., income); household composition and disability; race/ethnicity and language; and housing type/transportation to ensure allocation is based upon need (see Washington Tracking Network and select "Social Vulnerability to COVID-19"). It is not the intention of Washington state to begin with these highest risk areas but rather to ensure that special effort is made to deliver vaccine to the most vulnerable areas (defined as the 25 percent highest ranked areas against this index in the state).

These efforts may vary based on the circumstances. For example, if the way the vaccine is administered or stored limits the type of sites that can offer the vaccine, then we will have to take that into consideration when selecting sites to ensure the vaccine is available to communities in the most vulnerable areas. In the case of limited vaccines, we may distribute a marginally larger proportion of vaccines to the most vulnerable areas to ensure adequate access to these populations. In all cases, we will make these decisions consistent with the principles, criteria, and goal stated above.

ALLOCATION GUIDANCE WITHIN EACH PHASE

Given heterogeneity within each prioritized population, this section provides guidance on which individuals to prioritize keeping in mind the principles, criteria, and goal.

This guidance is the result of several months of engagement with expert groups and community partners to gather input and ideas. Given current information and federal guidance, we are providing guidance on Phase 1a and 1b that incorporates this input while staying aligned with the principles and criteria noted above. We are offering tentative ideas of populations that may be considered in future phases. The guidance will be updated to provide details on these other phases based on:

- New information from clinical trials and local data
- New federal guidance and vaccine recommendations
- Ongoing feedback from impacted communities, partners, sectors, and industries

In this guidance, population groups overlap and there are individuals who fit into multiple categories. When this is the case, the higher phase should take precedence. Current size estimates of these populations are available in **Appendix C**. Also, the order of the populations does not suggest any type of prioritization or risk stratification. In all circumstances, although reinfection appears uncommon during the initial 90 days after symptom onset, prior confirmation of COVID-19 infection will not exclude any individual from eligibility for COVID-19 vaccine and serologic testing is not being recommended prior to vaccination. Vaccines should be administered according to age groups for which the specific vaccine is authorized (e.g., Pfizer for 16 and over and Moderna for 18 and over).

Phase 1

Currently, we are limiting Phase 1 of the allocation framework to Phase 1a and 1b. Phase 1a is eligible for vaccine as of December 31, 2020. We anticipate Phase 1b will be eligible in mid to late January.

Phase 1a - Tier 1

Overarching Groups:

- **High-risk workers in health care settings** (clinical judgment should be applied to identify who is at greatest risk using the guidance below)
- **High-risk first responders** (clinical judgment should be applied to identify who is at greatest risk using the guidance below)
- **Residents and staff of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance**

Phase 1a focuses on (a) high-risk workers in health care settings and high-risk first responders in order to protect our medical care response capacity and (b) residents and staff of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance aiming to avoid hospitalizations, severe morbidity, and mortality. The table below identifies the desired objectives and guidance regarding what individuals would be prioritized for vaccine allocation in this phase. We provided recommendations that closely align with the Advisory Committee on Immunization Practices (ACIP) and initially include risk stratification given limited vaccine.

CDC provided initial COVID-19 vaccine supply projections for the first two months. Assuming Washington state receives approximately 2 percent of the total projections (Washington's approximate proportion of total U.S. population), our state was expected to receive between 150,000 to 350,000 doses in the first month and between

500,000 to 1 million doses in the second month (inclusive of second doses). Also note that many residents of long-term care facilities will be served via a federal pharmacy program that began in late December and draws down from the Washington state vaccine allotment. Given limited vaccine, sub-prioritization and sequencing of distribution to health care personnel was initially necessary. Furthermore, agencies have been encouraged to consider staggering vaccine schedules of teams to avoid potential clustering of worker absenteeism related to systemic reactions.

Beyond ACIP, this guidance was developed based on input and review by a number of experts including Washington advisory groups (Vaccine Advisory Committee, Disaster Medical Advisory Committee, COVID-19 Science Advisory Working Group, Association for Professionals in Infection Control), health care providers, and local health jurisdictions (including health officers).

PHASE 1A-1 **OBJECTIVE**	PHASE 1A-1 **GUIDANCE**

To protect those at highest risk of exposure, to maintain a functioning health system, and to protect highly vulnerable populations	*In the context of limited vaccine, this guidance includes the following sub-prioritization considerations:*
	• Personnel without known infection in prior 90 days
	• Workers in sites where direct patient care is being frequently delivered to confirmed or suspected COVID-19 patients, including sites where suspected patients are directed for COVID testing and care
	  ○ Example setting: hospital sites managing suspected/confirmed COVID patients; emergency departments; urgent care; clinics (walk-in, respiratory); home; isolation and quarantine facility
	  ○ Examples types of workers: health care workers; technicians; security; environmental, janitorial, and facility staff; non-remote translators; counselors; home health aides, caregivers, and companions
	• Workers frequently performing high-risk exposure procedures with suspected or confirmed COVID-19 patients
	  ○ Example procedures: endotracheal or cough inducing intubation; cough induction or cough inducing procedure (e.g., nasogastric tube); bronchoscopy; suctioning; turning the patient to the prone position; disconnecting the patient from a ventilator; invasive dental procedures and exams; autopsies; respiratory specimen collection; cardiopulmonary resuscitation; upper endoscopy; laparoscopic surgery; placement of chest tubes for pneumothorax
	• Workers exposed to/handling potentially SARS-CoV-2 containing specimens
	• COVID-19 testing site staff at high risk of exposure to suspected COVID-19 patients
	• First responders at high risk of exposure to suspected or confirmed COVID-19 patients via high public exposure and procedures
	  ○ Licensed emergency medical service frontline staff regardless of agency (e.g., fire, ambulance, hospital)
	  ○ Emergency workers providing patient transport/ambulatory support regardless of agency
	  ○ Personnel working in the field to provide oversight of these emergency medical service positions
	• Workers with elevated risk of acquisition/transmission with populations at higher risk of mortality or severe morbidity

	o Workers at long-term care facilities and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance (e.g., healthcare, environmental facility management, counselors, dining staff, etc.)
	    o Home health aides, care aides, caregivers, companions, etc.
	    o Workers with patients undergoing chemotherapy, chronic renal disease, dialysis, etc.
	• Workers (including pharmacists and occupational health staff) administering vaccines to Phase 1a and 1b populations
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	Residents and staff of long-term care facilities and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance and are unable to reside independently in the community:
	  • Example: skilled nursing facilities – facility engaged primarily in providing skilled nursing care and rehabilitation services for residents who require care because of injury, disability, or illness
	  • Example: assisted living facilities – facility providing help with activities of daily living; residents often live in their own room or apartment within building/group of buildings
	  • Examples of possible settings: adult family homes; group homes for people with disabilities (physical, developmental, intellectual); mental/behavioral health institutions; residential homeless shelters
	
	Where sub-prioritization is needed, consider:
	• Skilled nursing facilities caring for the most medically vulnerable residents and of congregate nature so they face the joint risk factors of severe disease/mortality and transmission due to their living settings
	• After skilled nursing facilities, consider broadening to other facilities, including:
	    o Assisted living facilities and adult family homes
	    o Residential care communities
	    o HUD 202 low-income senior housing
	    o Intermediate care facilities for individuals with developmental disabilities
	    o State Veterans Homes

Phase 1a (Tier 1) Additional Guidance

- We specifically use the terminology “workers in health care settings” and not “health care workers” because health agencies should consider the full spectrum of workers who might fit these conditions. Health care agencies should consider all types of staff (e.g., contracted, part-time, unpaid/volunteer) and the spectrum of staff who provide services (e.g., ambulatory, direct patient care, support services). ACIP provides similar guidance regarding defining healthcare personnel.[1]

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[1] **Healthcare personnel (HCP)** according to the CDC refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. These HCP may include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons (e.g., clerical, dietary, environmental services, laundry, security, maintenance, engineering and facilities management, administrative, billing, and volunteer personnel) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted among from HCP and patients.

- Special attention should be paid to workers in health care settings who are at high risk of exposure and may have inconsistent or limited use of PPE as well as those working in settings with inadequate environmental controls for recommended air exchange.

Phase 1a - Tier 2 (after completion of Tier 1)

Overarching Group:

- **All other workers at risk in health care settings**

The definition of healthcare settings as defined by CDC refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long term acute care facilities, inpatient rehabilitation facilities, nursing homes and assisted living facilities, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, and others.

PHASE 1A-2 **OBJECTIVE**	PHASE 1A-2 **GUIDANCE**
To protect those at highest risk of exposure, to maintain a functioning health system, and to protect highly vulnerable populations	**All other workers at risk of acquisition or transmission to COVID working in health care settings** • Workers who are at risk of acquisition or transmission of COVID because they are interacting in close proximity (less than 6 feet) with patients, co-workers, or specimens and are unable to remain socially distant (i.e., not include remote workers)

Phase 1a (Tier 2) Additional Guidance

- We specifically use the terminology “workers in health care settings” and not “health care workers” because health agencies should consider the full spectrum of workers who might fit these conditions. Health care agencies should consider all types of staff (e.g., contracted, part-time, unpaid/volunteer) and the spectrum of staff who provide services (e.g., ambulatory, direct patient care, support services).

- Across Washington, it is important that health care systems actively reach out to and provide access to COVID-19 vaccination for community-based health care workforce outside their systems and in their community. This includes other health care providers, school nurses, and behavioral health providers, etc., in order to compete this phase and ensure we have a protected healthcare system.

Comparison to the National Academies’ Framework (for reference only)

Phase 1a of the National Academies’ Framework and phase 1a of Washington’s guidance are generally similar given the focus on workers at risk in healthcare setting. This guidance also includes residents of community-based congregate care settings which is aligned with ACIP guidance.

Phase 1b

We are also issuing guidance on Phase 1b. This phase generally includes people who are high to moderate risk against the four risk criteria:

- Risk of acquiring infection
- Risk of severe morbidity and mortality

- Risk of negative societal impact
- Risk of transmission to others

In addition, we have applied equity as a cross-cutting lens and considered situations when certain groups are disproportionately affected due to social factors and/or other systemic inequities to mitigate for these factors.

Summary:

Phase 1b Tiers (in order)	Groups
Tier 1	• All people 65 years and older • People 50 years and older in multigenerational households
Tier 2	• High-risk critical workers 50 years and older who work in certain congregate settings
Tier 3	• People 16 years and older with 2 or more co-morbidities or underlying conditions
Tier 4	• High risk critical workers under age 50 in certain congregate settings (as noted above in Tier 2) • People (residents, staff, volunteers) in congregate living settings (e.g., correction facilities, prisons, jails, detention centers; group homes for people with disabilities) and people experiencing homelessness that access services or live in congregate settings (e.g., shelters, temporary housing)

Phase 1b - Tier 1

Overarching Groups:

- **All people 65 years and older**
- **People 50 years and older in multi-generational households**

The first tier focuses on protecting those who are driving hospitalization and face high rates of severe morbidity and mortality in order to reduce the burden on hospitals that keeps us in an emergency state. We also want to recognize that there are elders who may be vulnerable and unable to live independently similar to those in community-based, congregate care settings (Phase 1a) but their families care for them at home. In addition, we recognize that many families - especially those disproportionately affected by COVID - live in multi-generational homes that put the elders in the household at significantly higher risk for acquiring infection. Because these individuals are among disproportionately affected groups, they are also at risk for higher rates of severe morbidity and mortality.

PHASE 1B-1 **OBJECTIVE**	PHASE 1B-1 **GUIDANCE**
To prevent hospitalization and rates of severe morbidity and mortality	**All people 65 years and older** (about half of whom have co-morbidities that increase risk for severe outcomes if infected with COVID)
To prevent acquiring infection, hospitalization, and rates of severe morbidity and mortality	**People 50 years and older living in a multigenerational (2 or more generations) household** These individuals would be at risk either due to:

	• Vulnerability – specifically, an older adult or elder who cannot live independently *and* is being cared for by a relative or in-home caregiver or being cared for by someone who works outside the home • Risk of exposure – specifically, an older adult or elder who is living with and taking care of kinship (along the lines of a grandparent with a grandchild) • This group does not include an older adult who is able to live independently and is taking care of the individual's kinship/children

Phase 1b - Tier 2

Overarching Groups:

- **High-risk critical workers 50 years and older who work in certain congregate settings**

Phase 1b – Tier 2 which includes specific high-risk essential workers groups[2] age 50 and older who work in congregate settings. Occupational risk factors for COVID include setting (time inside vs. outside), proximity (to co-workers and/or customers), type of contact (physical, surface), duration, daily number of contacts, capability to assess possible infection (screening), consistent access to/ability to use protection, cleaning (frequency), and barriers to healthcare access. The course of the pandemic in Washington state indicates that specific groups of workers operating in congregate settings—such as, agricultural workers, food processing, incarceration facilities, and childcare workers — have experienced significantly elevated rates of infection given the nature of their working and/or living conditions. In addition, the working and living conditions contribute to transmission at work and in the community. We have also selected an age range that represents about half of the workers in these groups whose age is more associated with high rates of hospitalization, morbidity and mortality.

Phase 1b – Tier 2 also includes workers in childcare settings and K-12 educators and staff during in-person schooling or childcare. Not only do they face the risks noted above (note: there is growing evidence that older kids have higher risk of transmission) but remote education and care is also associated with very high risk of negative societal impact. There is strong evidence regarding the negative impact remote schooling is having on K-12 students regarding educational advancement and access to meals and support services for children, which disproportionately affects low-income families.

PHASE 1B-2 **OBJECTIVE**	PHASE 1B-2 **GUIDANCE**
To protect those who are at *high risk* of exposure and transmission given the nature of working and living conditions, to prevent hospitalizations and rates of severe morbidity and mortality, and to reduce negative societal impact by maintaining critical infrastructure for social and economic systems	**Critical workers 50 years and older with significantly high risk of exposure and transmission in congregate settings** Congregate setting refers to an environment where individuals work and/or live in an enclosed space where they are interacting with a high volume of people (i.e., supermarket) over extended time and not able to consistently social distance (i.e., be more than 6 feet apart). This does not include all critical worker groups but just a subset outlined below. This subset is focused on workers who are working in a congregate/enclosed setting working within 6 feet of other workers over an extended time (>3 hours in 24 hour

[2] See Washington Essential Critical Infrastructure Workers for most up-to-date list of essential worker groups

	day). Therefore, workers who are able to socially distance, work remotely or work off-site not in a congregate setting would not be included. Specific groups and guidance are outlined below: • *Congregate agriculture* – specifically those who work and/or live in a congregate setting interacting with a high volume of co-workers (vs. animals) over extended periods of time (i.e., >3 hours in 24 hour day). Relevant roles are more likely to include crop selection, production and packaging vs. equipment maintenance • *Congregate food processing* – specifically those who work and/or live in a congregate setting interacting with high volume of co-workers (vs. animals) over extended periods of time (i.e., >3 hours in 24 hour day) • *Workers in congregate grocery stores or food banks* - specifically those who work in a congregate setting interacting with high volume of co-workers over extended periods of time (i.e., >3 hours in 24 hour day). We encourage considering prioritizing retail stores of higher density/volume vs. where people are more able to be socially distant (e.g., wineries, coffee shops). • *Congregate staff in correction facilities, prisons, jails, detention facilities, and court settings* – specifically those who are interacting with high volume of individuals in a congregate interior setting over extended periods of time (i.e., >3 hours in 24 hour day). We encourage considering the spectrum of staff (e.g., facility management, security, counselors) who fit this exposure criteria. • *Congregate public transit* - specifically those who work in an enclosed (vs. outdoor) congregate setting interacting with high volume of co-workers or general public over extended periods of time (i.e., >3 hours in 24 hour day) to facilitate the transport of people. Settings may include bus, train, ferry, airport, and other high density transportation settings – or lower density settings where individuals are tightly constricted over an extended time, specifically taxies, limos and private vehicles over 4 people. Not include those who can work remotely or in office where can practice being socially distant. • *Firefighters, law enforcement and social workers responding to public health and safety* - specifically those who work in a congregate setting interacting with high volume of co-workers or general public over extended periods of time (i.e., >3 hours in 24 hour day). Not including administrators or those who can work remotely.
Same as above and to reduce the negative societal impact on families and children (that disproportionately affects low-income families)	**Workers 50 years and older in childcare settings** **K-12 educators and staff between 50 and 69 years of age who are working at the school (i.e., not remote workers)** • This category should consider the full spectrum of workers including administrators, environmental services staff, maintenance workers, school bus drivers, paraeducators, and all of who are essential to childcare and education • Childcare includes early learning and child care programs that are permitted to operate under DOH guidance for child care, youth development, and day camps. • Specifically, this group includes those who face substantially high risk of exposure given work conditions because they are operating in a congregate setting interacting with co-workers or youth over extended periods of time. • Attention should be given to the specific programs that reach children with special health care needs, individual educational plans, and technological gaps. • This group should not include those who are working remotely or in a role where they can practice being socially distant.

Phase 1b - Tier 3

Overarching Groups:

- **People 16 years and older with 2 or more co-morbidities or underlying conditions**

Phase 1b – Tier 3 includes people who have certain medical conditions that put them at increased risk for severe illness if infected with COVID leading to increased hospitalization, morbidity and mortality. The list of conditions is based upon research by CDC that is posted at the following site: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html. It is a living document that may be updated as science evolves.

PHASE 1B-3 **OBJECTIVE**	PHASE 1B-3 **GUIDANCE**
To prevent hospitalization and rates of severe morbidity and mortality	**People 16 years and older with 2 or more co-morbidities or underlying conditions** (See CDC's list of the conditions that put people at increased risk of severe illness from COVID-19.)

Additional Guidance for Groups Particularly Vulnerable to Severe Morbidity and Mortality

- Local health jurisdiction medical countermeasures would need to address strategies or contingency plans for reaching out to populations who may have multiple conditions but who experience inequities in social determinants of health (e.g., lower income households, racial/ethnic disparities in COVID-19 impact, limited English proficiency, people with access barriers to health care, people with disabilities, people live in a home with more people than rooms), especially as many of these groups may have no or limited access to health care providers to link them to vaccination providers. Particularly high-risk groups that may require tailored strategies to manage second dose reminders and follow-up include visitors to homeless shelters, substance use disorder facilities, agricultural workers, and people who are in high-risk groups but have no health care provider. Partners can use the Washington Tracking Network social vulnerability index to identify the most vulnerable census tract areas.

Phase 1b - Tier 4

Overarching Groups:

- **High risk critical workers under age 50 in certain congregate settings (as noted above in Tier 2)**
- **People (residents, staff, volunteers) in certain congregate living settings (e.g., correction facilities, prisons, jails, detention centers; group homes for people with disabilities) and people experiencing homelessness that access services or live in congregate settings (e.g., shelters, temporary housing)**

Phase 1b – Tier 4 includes two other high risk groups: (1) essential workers from the same groups as Tier 2 but under age 50 and (2) people in certain congregate living settings where there is a high risk of exposure and transmission. Recall risk is due to factors such as setting (time inside vs. outside), proximity (to co-workers and/or customers), type of contact (physical, surface), duration, daily number of contacts, capability to assess possible infection (screening), consistent access to/ability to use protection, cleaning (frequency), barriers to healthcare access, etc.

PHASE 1B-4 **OBJECTIVE**	PHASE 1B-4 **GUIDANCE**
To prevent hospitalization and rates of severe morbidity and mortality, including in settings that increase potential exposure - and to reduce negative societal impact by maintaining critical infrastructure for social and economic systems	**Critical workers under age 50 with significantly high risk of exposure and transmission in congregate settings.** See Phase 1b – Tier 2 for description of congregate settings to be considered. **Residents and staff in group homes for individuals with disabilities, including serious mental illness, development and intellectual disabilities, and physical disabilities as well as residential substance use disorder facilities not already covered in Phase 1** **People in prisons, jails, detention centers, and similar congregate facilities who work in such settings not already covered in Phase 1** **People experiencing homelessness that access services or live in congregate settings (e.g., temporary housing, shelters)** **People living or residing in domestic violence shelters**

Comparison to the National Academies' Framework (for reference only)

Phase 1b of the National Academies' framework and Phase 1b of this interim guidance refer to some similar groups. For instance, the National Academies' framework suggests prioritizing people with co-morbidities and underlying conditions associated with higher risk of severe morbidity and mortality. And this guidance includes elders and people with such co-morbidities and underlying conditions who are the major drivers of hospitalization and severe morbidity and mortality. The National Academies' framework also includes adults living in congregate care which the Washington guidance includes earlier in 1a. This guidance also includes essential workers at risk which that National Academies' framework has in Phase 2. However, this adjustment is consistent with ACIP recommendations.

Tentative Phase 2

As mentioned previously, no decisions have been made on future phases. More detail on defining these populations and where they fit into phases is expected based on further federal guidance, vaccine information and consultation with related agencies. However, current thinking is that Phase 2 of the allocation framework may expand to a larger proportion of the population who are at substantial risk based on the four criteria. It is worth reemphasizing that potential overlap may occur where certain individuals fit into multiple population groups. In that case, the earlier phase should take precedence. Also, the order of the populations does not suggest any type of prioritization or risk stratification.

This tentative framework includes risk stratifying workers across phases where critical workers at risk are in Phase 2 but critical workers not at risk (e.g., work remotely) are in Phase 3. If this approach is taken, we are identifying a set of factors to help workers assess their level of risk. A draft version of such a framework is available in **Appendix D** although we support adapting for the context. Relevant risk factors are likely to include setting (time inside vs. outside), proximity (to co-workers and/or customers), type of contact (physical, surface), duration, daily number of contacts, capability to assess possible infection (screening), consistent access to/ability to use protection, cleaning (frequency), and barriers to healthcare access.

Tentative Groups:

- **Critical workers in other settings who are in industries essential to the functioning of society and are at risk of exposure not already covered in Phase 1**
- **People 16 years and older with 1 comorbidity or underlying condition not already covered in Phase 1**
- **People with disabilities that prevent them from adopting protective measures**

TENTATIVE PHASE 2 **OBJECTIVES**	TENTATIVE PHASE 2 **GROUPS**
To protect those who are at *substantially* high risk of exposure given nature of work or living conditions and to reduce negative societal impact by maintaining critical infrastructure for social and economic systems	**Critical workers in other settings and sectors who are needed to maintain critical infrastructure and provide other important services** (see Washington Essential Critical Infrastructure Workers for most up-to-date list of essential worker groups) **and are at risk of exposure not already covered in Phase 1** • Example sectors: public health; emergency services; food and agriculture; energy; water and wastewater; transportation and logistics; communications and information technology; community-based governmental operations and essential functions; critical manufacturing; hazardous materials; financial services; chemical; real estate and mortgage; mortuary, funeral, embalmer, and cemetery services; defense industrial base • Example of risk exposure description: have regular direct public contact with general public or co-workers; not able to work remotely; may not be able to implement protective measures consistently • Sample roles: flight attendants; food and drug store retail; warehouse/delivery staff; postal staff; electricians; fuel infrastructure staff **Workers in industries essential to the functioning of society and are shown to be at elevated risk of infection because of other working or living conditions** • Example roles: transportation/utility workers living together
To reduce hospitalizations, severe morbidity and/or mortality	**People 16 years and older with 1 comorbidity or underlying condition not already covered in Phase 1** (See CDC's list of the conditions that put people at increased risk of severe illness from COVID-19.) **People with disabilities (developmental, mental, intellectual, physical) that prevent them from adopting protective measures** (e.g., unable to manage/tolerate masks)

Comparison to the National Academies' Framework (for reference only)

The Washington guidance tentative Phase 2 is more significantly changed from the Phase 2 in the National Academies' framework. Several of the critical worker categories have been moved to Phase 1b. In addition, the groups in congregate living were moved from Phase 2 to Phase 1b. And a portion of people with 1 co-morbidity were elevated to Phase 1b. Also, we added the category regarding people with disabilities that prevent them from adopting protective measure to recognize that some people with disabilities are not able to adopt protective measures – e.g., to wear masks, consistently wash hands, and/or communicate their symptoms effectively to protect themselves and others. Some groups are similar such as other critical workers who are at risk and a portion of people with 1 co-morbidity. ACIP has not developed a phase 2 so it is not feasible to compare.

Tentative Phase 3

Tentative Groups:

- **Workers in industries and occupations essential to the functioning of society and at increased risk of exposure not included in Phase 1 or 2**
- **Young adults/children under 16 years (if vaccine is authorized for those under 16 years)**

As mentioned previously, no decisions have been made regarding future phases and more detail on defining these populations and where they fit into phases is expected based on further federal guidance, vaccine information and consultation with related agencies. However, current thinking is that Phase 3 of the allocation framework includes: lower risk essential/critical workers; higher risk non-essential/critical workers; people under the age of 16. Essential/critical workers who are not at risk (e.g., can socially distance, work remotely, etc.) may be in this category given lower risk of exposure. This phase might also include people who are in non-essential/critical occupations but have high risk akin to Phase 2 workers to protect them from infection. People under the age of 16 will be considered once there is clinical data that enables recommendation.

TENTATIVE PHASE 3 **OBJECTIVES**	TENTATIVE PHASE 3 **GROUPS**
To protect those who are at *moderately* high risk of exposure and to support functioning of society	**Workers in industries and occupations essential to the functioning of society at low risk of exposure not included in Phase 1 or 2** ● For essential/critical workers, low risk of exposure description: occupational risk of transmission is lower than those in Phase 2 because they work in settings where distancing and protective measures are likely to be implemented without great difficulty ○ Example roles of essential critical infrastructure workers: worker in bank; remote worker; goods-producing ● For non-essential industries/occupations the risk would be more similar to Phase 2 essential workers (i.e., regular direct contact, high risk of exposure activities) ○ Example industries/occupations: entertainment; sports; barber shops
To prevent hospitalization and reduce transmission	**Young adults/children (under 16)** [note: will depend upon when clinical data is available]

Tentative Phase 4

Tentatively, Phase 4 includes everyone else residing in Washington state who did not have access to the vaccine in prior phases – including people who may not have formal occupations or people in non-essential industries/occupations who are not at risk (e.g., working remotely).

Comparison to the National Academies' Framework (for reference only)

The two frameworks are identical for Phase 3 and 4.

Comparison of Washington State Interim Guidance to ACIP

The Advisory Committee on Immunization Practices (ACIP) at CDC is continuing to develop their COVID-19 vaccine allocation guidance. Washington state has aimed to align our guidance with ACIP recommendations. The table below shows how our proposed framework compares to the ideas being discussed at ACIP as of December 22,

2020. It is worth noting that the two frameworks are using different terminology. ACIP's Tier 1b is more aptly compared to Washington state's Phase 1b Tier 1 and Tier 2. And ACIP's Tier 1c is more aptly compared to Washington state's Phase 1b Tier 3 and Tier 4.

PHASE	**ACIP** GUIDANCE (12/1/20)	**WA** INTERIM GUIDANCE	COMPARISON
1a	Health care personnel Long-term care facility residents	Tier 1 High-risk workers in health care settings High-risk first responders Residents of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance Tier 2 All other workers at risk in healthcare settings	This phase is the same although the Washington guidance is opting to use language that is more aligned with what we shared in external engagement with community partners. Washington guidance also initially prioritized higher risk workers in healthcare until more vaccine was available.
ACIP 1B **WA 1B Tier 1 & 2**	Persons ≥ 75 years of age	Persons 65 years and older Persons 50 years and older living in a multigenerational home	Washington expands the number of elders and considers other elders who are at risk giving living conditions and exposure.
	Frontline essential workers (including manufacturing, construction, postal services and a broader set of food/agriculture groups)	Essential workers in certain congregate settings over 50	ACIP has all frontline critical workers earlier than Washington and includes more groups. Washington focuses on essential workers in congregate settings who are 50 and older therefore at greater risk of exposure and severe morbidity and mortality.
ACIP 1C **WA 1B Tier 3 & 4**	Persons aged 65-74	People (residents, staff, volunteers) in certain congregate settings	ACIP further expands the age category. Washington considers groups who are at risk given their living or working conditions.
	Persons aged 16-64 with medical conditions associated with severe outcomes	People with 2+ co-morbidities or underlying conditions	Both frameworks consider people who are at risk due to co-morbidities or underlying conditions.
	Other essential workers (not frontline)	Essential workers in certain congregate settings under 50	ACIP includes all other essential workers. Washington includes other essential workers in congregate

			settings under 50 and reserves other critical workers for Phase 2.
2	ACIP TBD – (may be lower prioritized co-morbidities)	Other essential workers People 16 years and older with 1 co-morbidity People with disabilities that are unable to protect themselves	Washington includes other people who are likely at risk given occupational role, co-morbidity or disability.
Other future groups	Non-essential workers Youth (under 16) Other		

COORDINATION OVERVIEW

Allocation Roles & Responsibilities

The federal government is managing overall allocation of COVID-19 vaccine across the states and territories, and to tribal nations through the Indian Health Service or states. The federal government will rely on the ACIP to develop recommendations for who will receive vaccine and a framework to guide prioritized allocation of vaccine. It is the responsibility of each state to provide estimated sizes for the prioritized populations within that framework to inform allocation. As such, the Department of Health will work with local health jurisdictions, health partners, statewide and local agencies, business partners, education systems, and more to gather input on the size of prioritized populations, identify geographic distribution of these populations, and identify and assess the capacity of providers for administering vaccine.

Given that this is interim guidance, patience and flexibility is requested from our partners as the prioritized populations may adjust over time. Ultimately, it will be the responsibility of the Department of Health to determine allocation across sites using the factors noted in the "Prioritizing within Each Phase" section. One exception is that the federal government is developing contracts with CVS and Walgreens pharmacy chains to provide vaccine to long-term care facilities who opt in. The federal government will work to gather vaccine orders from pharmacies and manage this distribution separately. The federal government is also engaging other national health care partners and federal agencies for direct vaccine distribution, such as select national pharmacies, Veterans Hospital Administration, Bureau of Prisons, Department of Defense, Department of Homeland Security, and others.

Information Systems & Safety Monitoring

Washington state will rely on several information platforms to assess provider capacity, monitor supply, and track vaccine coverage (see **Appendix E** for overall visual). The state will request enrolled provider sites to submit information to support allocation decisions needed for when vaccine supply is limited. This could include a survey to enrolled providers to identify size of populations prioritized for vaccination served by the enrolled site. Additional population and enrolled provider site information will also be collected during provider enrollment.

To enroll, providers will enter required CDC provider enrollment data regarding populations served, facility type, and vaccine storage units into a program called REDcap. The Washington state vaccine program will export the data twice weekly from REDCap and import into the CDC IZ Datalake to support processing provider vaccine orders and inclusion in Vaccine Finder for reporting daily inventory. Providers are required to have an active exchange Information Sharing Agreement (ISA) with the Washington State Immunization Information System (WAIIS). This agreement allows providers to utilize the IIS to order, receive, and track their vaccines at a dose level. The data can be entered into the WAIIS in multiple ways. The Washington state vaccine program is working to obtain a license to utilize a program called PrepMOD and will test PrepMOD's ability to share dose level accountability from this system into the WAIIS to monitor inventory levels at provider sites. In addition, the Washington state vaccine program is working on updating data requirements of providers regarding patients to enable monitoring vaccine coverage of prioritized populations. The program is working to develop dashboards to share information regarding supply and coverage on the Department of Health website.

In addition to these systems for monitoring supply, demand, and coverage, other systems are in place or being developed to monitor vaccine safety after administration and communicate safety information. This approach includes:

- Using established systems to implement heightened safety monitoring for COVID-19 vaccines
- Developing new platforms and leveraging other federal data sources to complement existing systems
- Communicating clearly on the existing vaccine safety process and systems and providing COVID-19 vaccine safety data and monitoring results once available

Washington state will use ongoing analysis of the Vaccine Adverse Event Reporting System (VAERS) data to identify any safety concerns that are reported to the federal government. This information will also be collated and shared regularly to the Vaccine Advisory Committee and Vaccine Science Advisory Workgroup for local review and guidance.

Washington will also promote the new V-Safe smartphone app from the CDC. The app allows someone use their smartphone to tell CDC about any side effects after getting the COVID-19 vaccine. They'll also get reminders about when to get their second vaccine dose.

Community Engagement & Communication

We are committed to providing COVID-19 vaccine in a safe, equitable, and effective manner that includes ensuring communities across Washington have access to the information they need to make informed decisions about their health. We will coordinate and disseminate the information through existing systems and partners to ensure the right messages reach the right people in the right way. We will proactively work to build new systems and partnerships to connect with communities who we are not reaching by our current channels. We recognize that we do not have all the information and that the situation will continue to evolve. However, we are committed to sharing updates in a transparent, timely, and accessible way while collaborating with key partners to ensure all COVID-19 vaccine messaging and information is community-informed, culturally relevant, linguistically appropriate, and accessible.

Our communication and engagement objectives will be accessible and culturally and linguistically appropriate, and include:

- Create new and strengthen existing community partnerships to build trust, confidence, and bi-directional communication channels, particularly with communities most disproportionately impacted by COVID-19.

- Collaborate with key partners to ensure all COVID-19 vaccine messaging and information is community-informed, culturally relevant, linguistically appropriate, and accessible.
- Invest in key partners, organizations, and groups to recognize their role as trusted messengers and channels.
- Provide timely, accurate, and credible information to the people of Washington on the COVID-19 vaccine. This information will address questions and concerns we are hearing from communities, and will include the benefits and risks of vaccination, risks of COVID-19 disease, and vaccine safety data.
- Encourage continuing safe behavior practices, such as masking, social distancing, gathering in small groups, and hand washing.

To start, we want to build confidence in the process to find an approved COVID-19 vaccine and the vaccine itself by sharing accurate and credible information about the safety of the vaccine. We also want to explain who will be prioritized when the vaccine is available and why. Then we will focus our communications on sharing who is currently approved for the vaccine, what they need to know, and where to get vaccinated. Our communications work is an iterative process and audience feedback, outreach, and evaluation will be a continuing part of the process to make sure our communications are effective and relevant.

Supporting Eligible Individuals to Know When and Where to Get a Vaccine within a Phase or Tier

As noted above, we want to help people know what phase they are in, when it is their turn to get vaccine, and where they can go. Multiple communication strategies will be used to reach out to different groups to share these messages in a community-informed, culturally relevant, linguistically appropriate, and accessible manner.

In addition, we have decided to try using technology to facilitate this process and support our own understanding of demand to inform planning and implementation. The proposed approach starts with a survey tool (called Phase Finder) in which a person answers a series of questions about their age, health condition, living conditions, employment role, etc. An algorithm is used to inform the person of what phase they are in and let them know if their phase is eligible to seek vaccine.

If the person is eligible, then the individual uses the confirmation to demonstrate eligibility at the site for vaccine administration. In addition, there is a link to a site that shares which providers are offering vaccines and where they are located to help the person identify a vaccine location. If the individual is not yet eligible, then the person can share mobile or email information to get an alert when the phase is eligible or the individual can check back. Another benefit of this technology is that the survey includes a question asking about likelihood to get vaccinated which will help the department understand likely demand of different groups to inform vaccine allocation and when to move to the next phase.

Conclusion

We want to acknowledge and thank all of the individuals, communities, partners, and groups who have, and are, participating with us during this planning process. We greatly value the feedback we have received and the time that others have invested in this ongoing effort. We will continue to refine and finalize each phase of this guidance as we learn more, and we are committed to sharing updates with you that are timely, transparent, and accessible. In conclusion, we simply wish to reiterate our overall gratitude. Many people shared, and continue to share, the impacts of COVID-19 on their lives, their questions about the vaccine, and what they want for us to

consider as we make difficult decisions about vaccine prioritization. We hear your stories and experiences and we appreciate your trust in sharing them with us.

In partnership and with gratitude,

The Washington State Department of Health COVID-19 Vaccine Planning Team

APPENDICES

Appendix A: Key Data on the Impact of COVID-19 on Specific Populations from the National Academies & Application Excerpt

POPULATION	KEY IMPACT DATA
Black	Compared to non-Hispanic White populations, this group has a case rate that is 2.6 times higher, a hospitalization rate that is 4.7 times higher, and a death rate that is 2.1 times higher (United States) (CDC, 2020 a,b)
Hispanic/Latinx	Compared to non-Hispanic White populations, this group has a case rate that is 2.8 times higher, a hospitalization rate that is 4.7 times higher, and a death rate that is 1.1 times higher (United States) (CDC, 2020 a,c)
American Indian and Alaska Native	Compared to non-Hispanic White populations, this group has a case rate that is 2.8 times higher, a hospitalization rate that is 4.6 times higher, and a death rate that is 1.4 times higher (United States) (CDC, 2020 a,b)
Native Hawaiian and Pacific Islander	Group has experienced mortality from COVID-19 at a rate up to 5 times its proportion of the population compared to the general population (United States) (Wong, 2020)
Older adults (≥65 years)	Group accounts for approximately 80% of reported deaths related to COVID-19 (United States) (CDC, 2020d) Population-level COVID-19 mortality risk is estimated to be 16- to 52-fold higher (United States) and 30- to 100-fold higher (worldwide) for this group than for younger people (Ioannidis et al., 2020)
Older adults (>80 years)	Group is experiencing a mortality rate 5-fold greater than average (United States) (Nikolich-Zugic et al., 2020) Group is experiencing an "overwhelming percentage" of severe outcomes due to COVID-19 (worldwide)
People with underlying or comorbid conditions	Group is 6-fold more likely to be hospitalized and 12-fold more likely to die from COVID-19 as people without underlying conditions (United States) (CDC, 2020e). Group is at greater risk of SARS-CoV-2 infection (Sanyaolu et al., 2020)
People who live and/or work in congregate settings	Older adults living in senior living facilities are at a high risk of severe COVID_19 (Nikolich-Zugic et al., 2020) Long-term care facility residents accounted for half of >10,000 COVID-19 deaths reported by April 2020 (United States) (Chidambaram, 2020)

Sex	Men with COVID-19 are more at risk for worse outcomes and death than women, independent of age (China) (Jin et al., 2020)
Children	Children and adolescents account for 10 percent of COVID-19 cases and less than 0.3 percent of deaths (United States) (AAP and CHA, 2020) Among children with COVID-19, 1.8 percent of cases resulted in hospitalization (United States) (AAP and CHA, 2020) 78 percent of deaths among adolescents (under 21) reported to the DCD between mid-February and the end of July 2020 were people from Black, Hispanic and Latinx, or American Indian and Native Alaskan communities (Bixler et al., 2020)
People who are pregnant or breastfeeding	Group may be at increased risk of developing severe COVID-19 disease that requires intensive care unit admission and mechanical ventilation (Cohen, 2020b) Black and Hispanic women who are pregnant appear to be disproportionately at risk of severe disease and hospitalization (United States) (Ellington et al., 2020) Babies born to women infected with SARS-CoV-2 during pregnancy appear to be more likely to be born preterm of require neonatal intensive care (Allotey et al., 2020)

NOTE The following groups are omitted from the table due to lack of COVID-specific epidemiological data: people who are undocumented, people with mental and physical disabilities, and people experiencing homelessness.

EXAMPLE Application of criteria for prioritization to different sub-groups using scientific data, community input, and local data to inform prioritization. Note: 1 – 5 (Low to High) and WA outbreaks considers frequency and relative overall size of outbreaks in Washington State.

POPULATION GROUP	RISK OF INFECTION	RISK OF MORBIDITY / MORTALITY	RISK OF TRANSMISSION	RISK OF NEGATIVE SOCIETAL IMPACT	EQUITY	WA OUTBREAKS
Ag workers	4	3	5	5	5	+
Food process.	4	3	5	5	5	+
Manufact. Line	4	3	5	5	5	+
Congregate construction	4	3	5	5	5	+
Incarceration Facil. Staff	3	2	5	4	5 (residents)	+

Childcare	3	3	3	5	5	
K-12 staff	2	3	3	5	4 (students)	

Appendix B: COVID-19 Expert Group Participant Lists

Vaccine Advisory Committee

Chair

- Dr. Kathy Lofy, State Health Officer, Department of Health (Chair)

Managed Care

- Dr. John Dunn, Kaiser Permanente

American Indian Health Commission for Washington (AIHC)

- Wendy Stevens

State Agency Healthcare Purchasers

- Jean Gowen, Health Care Authority
- Christopher Chen, Health Care Authority

National Association of Pediatric Nurse Practitioners (NAPNAP)

- Tara Tumulty, MSN, CPNP, ARNP

Naturopathic Medicine

- Dr. Mary Alison Koehnke, ND, Washington, Association of Naturopathic Physicians

Washington Academy of Family Physicians (WAFP)

- Dr. Susan Westerlund
- Dr. Usha Rao

Washington Chapter of the American Academy of Pediatrics (WCAAP)

- Dr. Daniel Moorman
- Dr. Stephen Pearson

Washington State Association of Local Public Health Officers (WSALPHO)

- Dr. Amy Person, Health Officer, Benton Franklin Health District
- Dr. Rachel Wood, Health Officer, Lewis County Public Health and Social Services
- Sarah Murray, Walla Walla County Department of Community Health
- Tristen Lamb, Public Health Director, Kittitas County Public Health Department

Public Health--Seattle & King County

- Dr. Jeffrey Duchin, Chief, Communicable Disease Control

Internal Medicine Organization

- Dr. Mary Anderson, Washington Chapter of American College of Physicians

Washington State Pharmacy Association

- Dr. Jenny Arnold, Pharm.D., Director of Pharmacy Practice Development

Office of the Superintendent of Public Instruction (OSPI)

- Annie Hetzel, MSN, RN, NCSN, School Health Services Consultant

Childcare

- Anita Alkire MS, RN, Public Health Nurse Consultant, Child Care Health Program at Public Health – Seattle and King County

Urban Indian Health Institute

- Amy Poel, Epidemiologist

Northwest Tribal Epidemiology Center

- Tam Lutz, Project Director

Consultants

- Dr. Linda Eckert, Consultant
- Dr. Beth Harvey, Consultant
- Dr. Edgar Marcuse, Consultant

For more information, visit:
https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/Immunization/VaccineAdvisoryCommitteeVAC

SARS-CoV-2 Vaccine Scientific Advisory Workgroup

Members:

- Dr. John Dunn, Kaiser Permanente
- Dr. Jeff Duchin, Public Health Seattle-King County
- Dr. Edgar Marcuse, Emeritus Faculty, University of Washington; Seattle Children's Hospital
- Jenny Arnold Pharm.D, Washing State Pharmacy Association
- Dr. Alisa Kachikis, Faculty University of Washington
- Kirsten Senturia PhD Faculty University of Washington
- Dr. Mary Koehnke, ND
- Dr. Stacy Cecchet, Washington State Department of Health
- Emily Hilderman DNP, ARNP
- Darcy Jaffe, Washington State Hospital Association
- Albert Munanga, DrBH, MSN, RN
- Dr. Rewa Choudhary, Seattle Children's Hospital
- Heather Kim, pharmacy student
- Kathy Bay, RN, DNP, Washington State Department of Health
- Amy Sullivan, PhD, Washington State Department of Health

Disaster Medical Advisory Committee

Members

- Iain Asplin, MD, PhD, Pediatric Critical Care Physician, Mary Bridge Children's Hospital
- Eileen Bulger, MD, Trauma Surgeon, Harborview Medical Center
- Joel Edminster, MD, Emergency Medical Services Medical Director, City of Spokane - Fire Department
- Aaron Grigg, MD, Ambulatory Primary Care Clinician (pediatrics), Yakima Valley Farm Workers Clinic

- Mary King, MD, MPH, Pediatric Critical Care Physician, Harborview Medical Center
- Hal Quinn, MD, Ambulatory Primary care Clinician (Pediatrics), Mercer Island Pediatrics
- Adam Richards, RN, Director of Nursing, Providence Sacred Heart Medical Center & Children's Hospital
- David Roesel, MD, MPH, Hospitalist (Adult), Northwest Hospital & Medical Center
- Vicki Sakata, MD, Emergency Medicine Physician, Northwest Healthcare Response Network
- Yuan-Po Tu, DVM, MD, Ambulatory Primary Care Clinician (adult), The Everett Clinic - Mill Creek
- Curtis Veal, MD, Adult Critical Care Physician, Swedish Medical Center
- Bradley Younggren, MD, Emergency Medicine Physician, EvergreenHealth Kirkland

Appendix C: Size Estimates of Population Groups

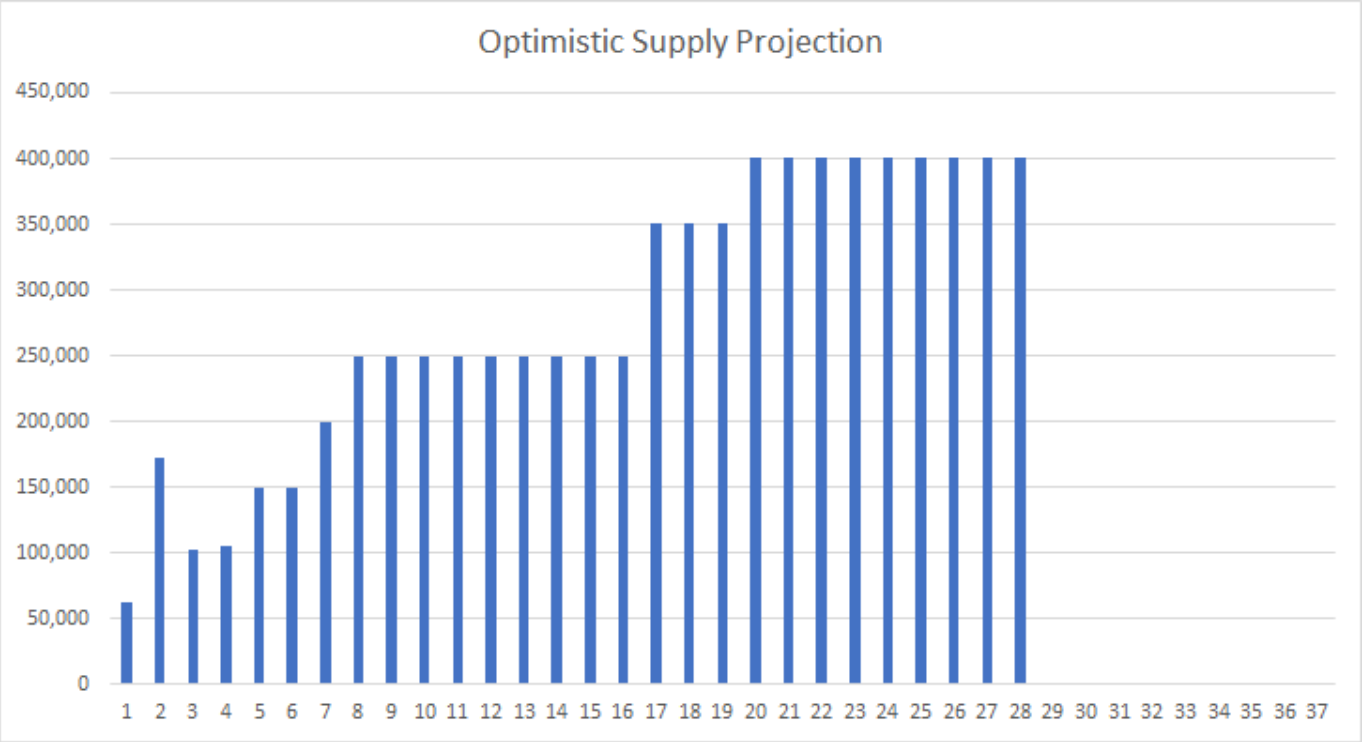
Below is a chart with our best estimates of the size of different population groups.

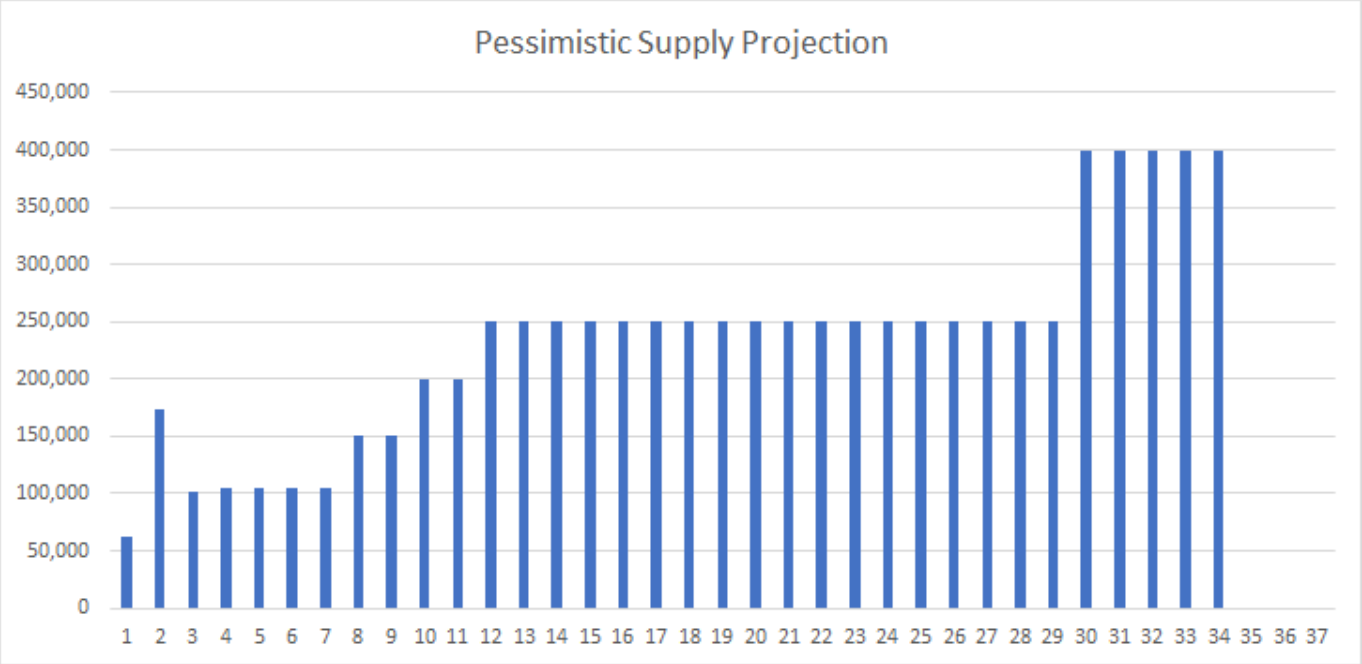
PHASE	POPULATION GROUP	SIZE ESTIMATE (not overlapping)
1a - Tier 1	High-risk workers in healthcare settings	***320,000***
	High-risk first responders	***30,000***
	Residents of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance	***100,000***
1a – Tier 2	Other workers at risk in healthcare settings	***400,000***
1b – Tier 1	People 65 and older	***1,134,000***
	People 50-64 in a multigenerational home	***350,000***
1b – Tier 2	High risk workers in certain congregate settings aged 50-64	***95,000***
1b – Tier 3	16-64 year olds with 2 or more co-morbidities or underlying conditions	***1,100,000***
1b – Tier 4	High-risk workers in certain congregate settings under 50 years	***220,000***
	People (residents, staff, volunteers) in congregate living settings	***150,000***
2	16-64 year olds with only 1 co-morbidity not already covered	***1,400,000***
	People with disabilities that prevent them from adopting protective measures	***20,000***
	Critical workers in other settings who are at risk	***200,000***
3	Workers in industries and occupations essential to the functioning of society and at risk of exposure	***300,000***
	Young adults/children (under 16)	***1,700,000***
4	Everyone residing in Washington State who did not have access to vaccine in previous phases	***200,000***

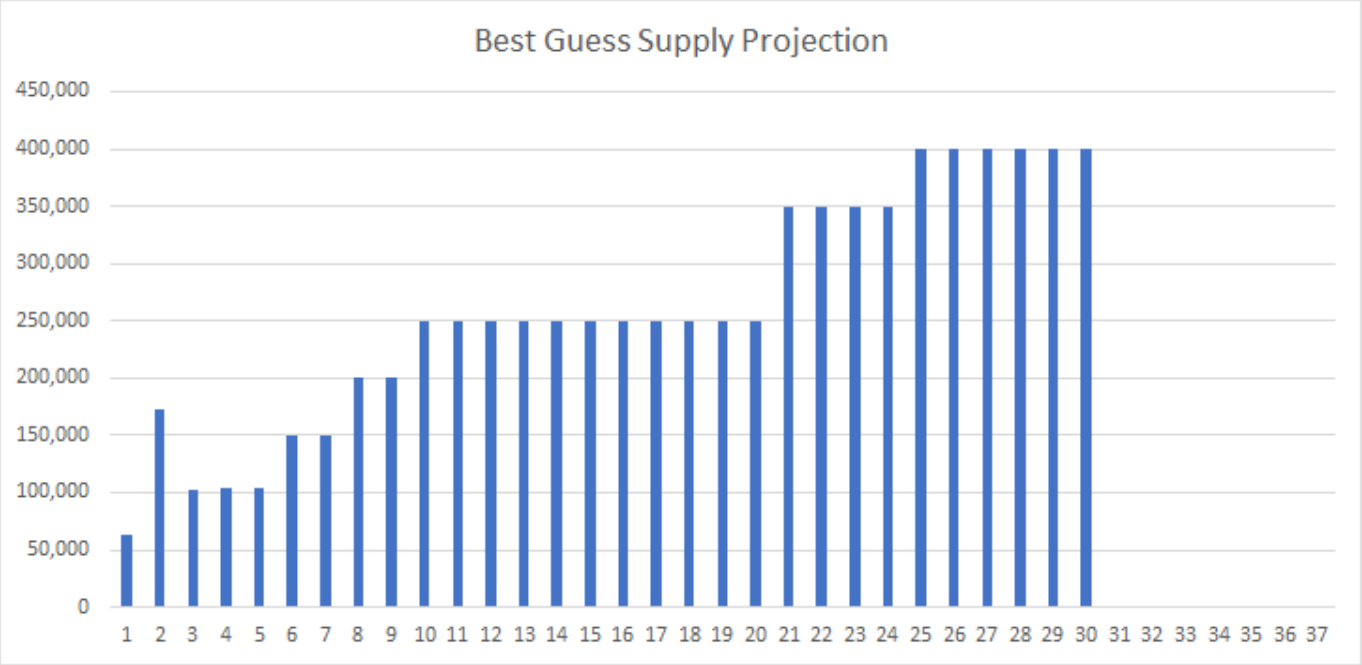
NOTE A common question asked is when certain phases will begin. The truth is that we do not know because it depends on many unknown factors such as how much vaccine we are expecting each week/month, if/when there will be a new vaccine approved, what is the demand of different population groups, how quickly we can administer vaccines, etc. As illustration, below are three different scenarios of supply projects (as of 1/6/21):

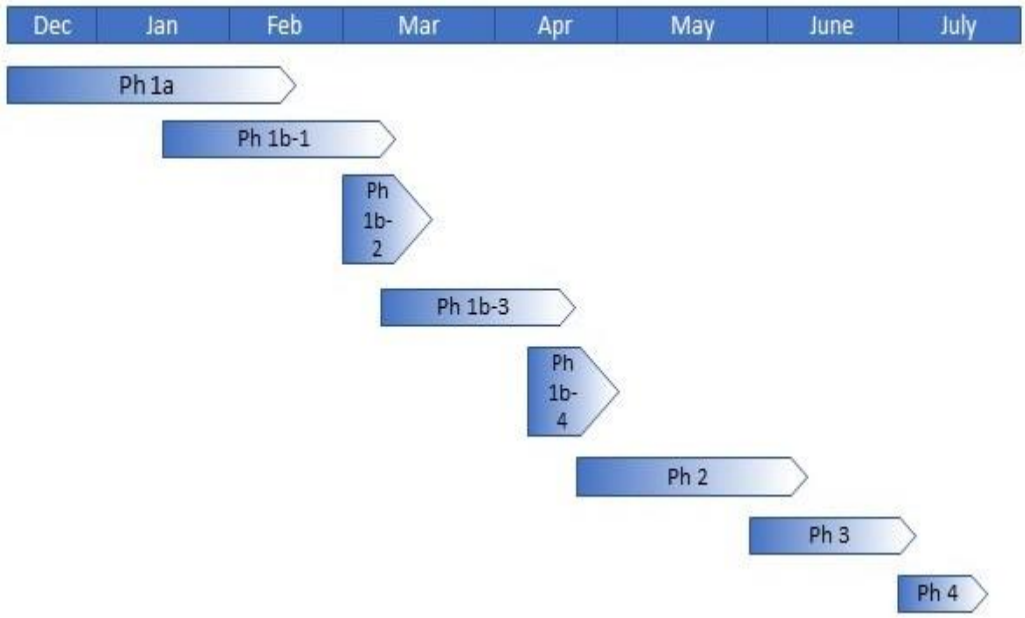
1. Optimistic – includes high estimations of supply each week and a new vaccine supplier by April
2. Pessimistic – includes lower estimations of supply each week and a new supplier in July

3. Best Guess – includes moderate estimations of supply each week and assumes a new supplier in May. Below this scenario we have included an illustration of how the different phases and tiers might align against these supply projections over time. This is highly illustrative and very likely to change.









[Figure Above: ***Illustrative*** Roll-out of Phases over Time]

Appendix D: Draft Worker Risk Stratification Resource Tool

Agencies outside health care may need to risk stratify their workers to identify eligibility by phase. Workers may also want to assess their own level of risk. To support the process, the Department of Health is awaiting federal guidance and working with different state agencies to develop a resource tool. Below is a **draft version** that is being developed in consultation with several agencies and will need to be refined with federal guidance: we encourage waiting for an updated version but are providing the draft version given strong interest in this topic. The criteria guiding this risk stratification are the same as the overall framework: risk of acquisition; risk of severe morbidity or mortality; risk of transmission; risk of negative societal impact [note: this last risk elevates critical

workers at highest risk over non-critical workers at highest risk in the phased approach] (see State of Washington's Safe Start guidance for the most recent list of critical workers). The framework below was developed as a tool to help worker organizations and the workers themselves to think about identifying roles in their sector or industry that are at highest risk vs. moderate risk vs. low risk. This is a guide – not a checklist. So a highest risk worker does need to fit all the classifications but several (e.g., approximately 3 or more) of the classifications. Similarly, roles should fit according to the classifications that generally describe the nature of the role. If you need additional guidance to think about risk, please consult CISA guidance and OSHA guidance.

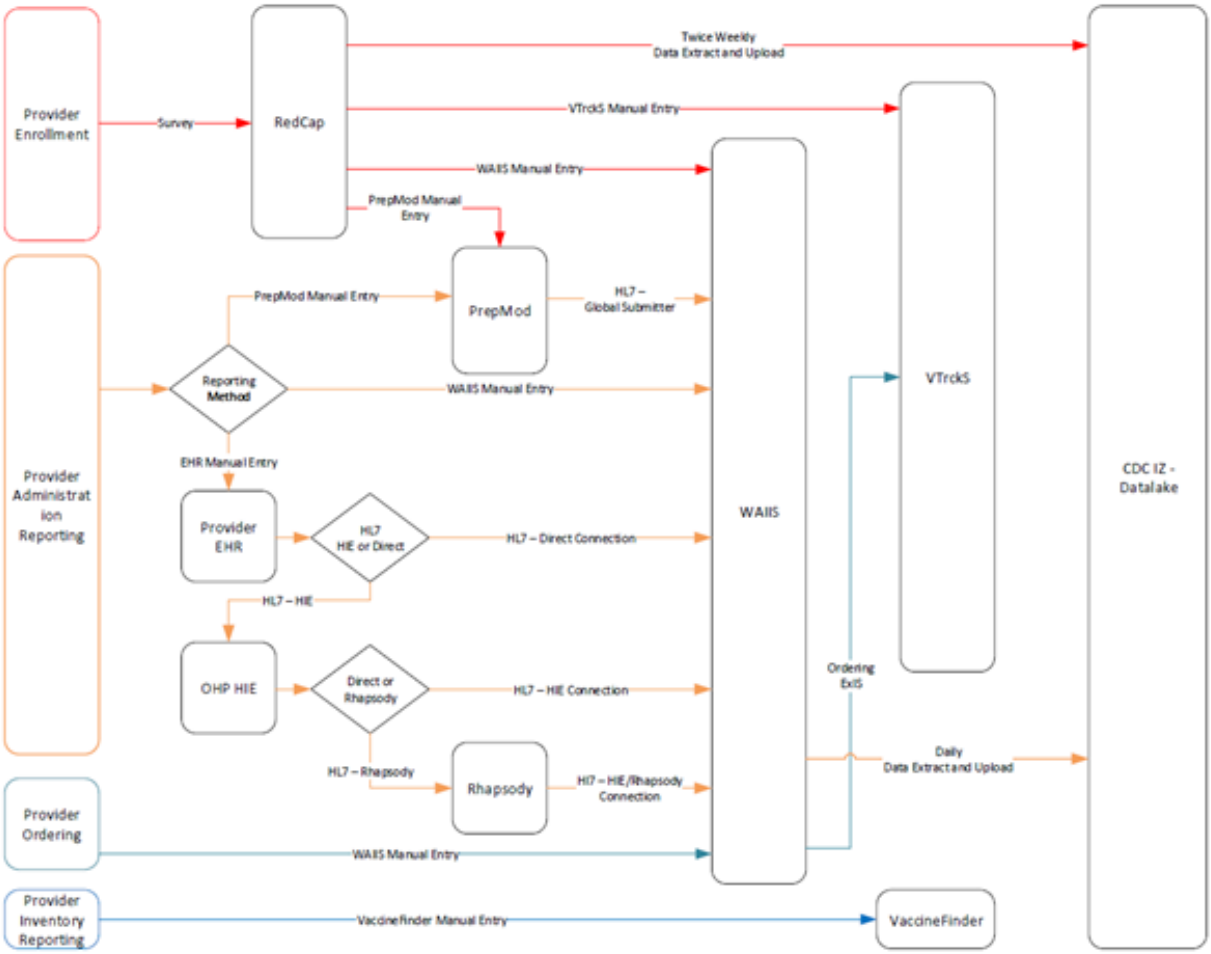
Classifications	**Highest risk** (3 or more of the factors below)	**Moderate risk** (1-2 of the factors under highest risk or fit with description below)	**Low risk** (fit with description below)
***Work setting*:** Do workers work together inside or outside?	Predominantly inside	Mix of inside and outside	Predominantly outside
***Housing situation*:** Do they live together (e.g., sleep, eat meals)?	Yes	No or very limited	No
Transport situation: Do they travel to or from work in crowded settings and/or travel together during work?	Yes (Over an hour within 6 feet of others)	Mixed (Less than an hour cumulative over 24 hours at 6 feet)	No (Travel together; over 6 feet separation)
Engagement with vulnerable populations: Does the role directly care for/engage with vulnerable groups?[3]	Yes	Sometimes	No
***Proximity*:** How physically close are workers (and customers) to each other?	Less than 6 feet (2 meters)	N/A	More than 6 feet (2 meters) or N/A
***Duration*:** How long does an average direct interaction with another person last?	15 minutes or longer cumulative per 24 hrs for interaction	Less than 15 minutes cumulative per 24 hrs for interaction	No direct contact
***Type of contact*:** Do workers touch shared surfaces, common items, and other workers or customers?	Significant sharing of surfaces and items with customers and/or coworkers	Limited sharing of surfaces and items with customers and/or co-workers	Low to no sharing of surfaces and items with customers and/or co-workers

[3] Roles might be doula, caregiver, healthcare interpreter, community volunteer, community health worker. Vulnerable populations include people over 65, people with comorbidities, pregnant women, and people with disabilities.

***Capability to assess possible infection*:** Are there screening protocols that protect workers (and customers) from interactions with contagious people?	Not able to consistently screen all people with direct contact (workers, customers) for COVID-19 symptoms, exposure, and fever	Able to consistently screen all people with direct contact (workers, customers) for COVID-19 symptoms, exposure, and fever	Able to consistently screen all people with direct contact (workers, customers) for COVID-19 symptoms, exposure, and fever or N/A given remote
***Number of different contacts*:** How many close contact interactions with other people occur daily?	More than one direct contact/day with close contacts or any contacts if not able to screen	Few contacts with ability to screen	No close contact interactions
***Cleaning*:** How frequently can shared or common facility surfaces be sanitized and cleaned?	Challenging to consistently sanitize and clean surfaces	Able to consistently sanitize and clean surfaces	Able to consistently sanitize and clean surfaces or N/A given remote working status
***Ability to protect themselves*:** How consistently are these workers able to socially distance and use protective measures?	Not able to implement protective measures, including social distancing	Not able to consistently implement protective measures, including social distancing	Able to consistently implement protective measures, including social distancing or N/A given remote working status
***Personal protective equipment*:** How adequate is the worker's supply and access to PPE?	Inadequate or inconsistent access to PPE needed given nature of work	Has consistent access to adequate PPE or N/A given nature of work	N/A
Disabilities: Are workers unable to observe protective measures such as wearing face masks or other PPE due to an underlying disability?	Yes	N/A	N/A
Healthcare access: Do the workers in this role generally have **access barriers** to healthcare? For example: • People with limited transportation • People who live far from healthcare services • People with limited English proficiency • Individuals with disabilities • People without insurance • Undocumented people	Majority	Some	Limited

Appendix E: COVID-19 Vaccine Information System Visual

Source: Washington State Department of Health



Appendix F: Community Engagement Questions

Results of the survey, interviews, and focus groups – and all future engagement activities – are available at https://www.doh.wa.gov/Emergencies/COVID19/VaccineInformation/Engagement.

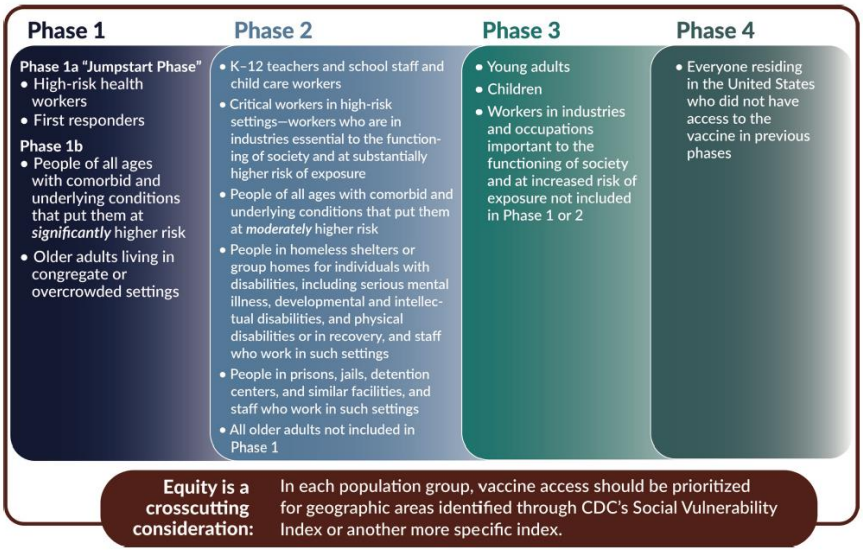
Public Feedback Survey Questions

PART ONE: HOW ARE YOU FEELING ABOUT COVID-19?

1) How worried are you about getting COVID-19?
2) How bad is being sick with COVID-19?
3) How much would the COVID-19 vaccine protect you and your family from COVID-19 disease?
4) Do most people in your life get vaccinated?
5) Do you think you will get the COVID-19 vaccine?
6) Do you have any fears about the COVID-19 vaccine?
7) If you get the COVID-19 vaccine, where would you prefer to get it?

PART TWO: HOW SHOULD WE DECIDE WHO GETS THE VACCINE FIRST?

8) How much do you agree with the inclusion of these six principles?
    1. Maximization of social benefits
    2. Equal regard
    3. Mitigation of health inequities
    4. Fairness
    5. Evidence-based
    6. Transparency
9) How much do you agree with these four considerations?
    1. Risk of acquiring infection
    2. Risk of severe morbidity and mortality
    3. Risk of negative societal impact
    4. Risk of transmitting disease to others
10) The National Academy of Medicine has created this phased approach to vaccine allocation for COVID-19. Final prioritization depends upon things that are unknown at this time, such as which groups will be approved for the vaccine. We are still interested in feedback on this approach to help us plan. Please review the image below and provide feedback on the specific questions that follow.



11) How much do you agree with how these different groups are prioritized? Check only one column.
    1. High risk heath workers
    2. High-risk first responders
    3. People with underlying conditions that put them at significantly risk
    4. Older adults living in congregate and overcrowded settings
    5. K-12 teachers and staff and child care workers
    6. Critical workers in high risk settings (example: people at high risk for exposure)
    7. People with underlying conditions that put them at moderately higher risk
    8. People in homeless shelters or group homes for individuals with disabilities
    9. People in prisons, jails, detention centers
    10. Young adults
    11. Children

12) Until there is enough vaccine for all people, we will continue to have to make difficult decisions about who should be offered the vaccine first. We will be looking at many different factors. How would like us to consider the following factors?
    - People with access barriers to health care
      People at risk for severe illness
    - People at higher risk for exposure
    - People who are at higher risk for spreading COVID-19 to high risk populations
    - People essential to health and wellbeing of populations at higher risk
    - People who live in areas with greater spread
    - People who have been disproportionately impacted by COVID-19 because of systemic inequities

PART THREE: TELL US ABOUT YOURSELF (optional)

13) Do you work in any of the following sectors? Essential business includes workers, businesses, and industries who are deemed essential by the State of Washington's Safe Start guidance and are at higher risk for COVID-19 exposure.
    a) Health care – And I think my position makes me at high risk for COVID-19
    b) Health care – And I don't think my position makes me at high risk for COVID-19
    c) Essential business – And I think my position makes me at high risk for COVID-19
    d) Essential business – And I don't think my position makes me at high risk for COVID-19
    e) First responder - And I think my position makes me at high risk for COVID-19
    f) First responder – And I don't think my position makes me at high risk for COVID-19
    g) Teacher or school staff
    h) Early learning or day care provider
    i) None of the above
14) Do you identify as someone who is personally at increased risk for COVID-19 because of your race/ethnicity?
15) Do you identify as someone who is personally at increased risk for COVID-19 because of your disability status?
16) Do you identify as someone who is personally at increased risk for COVID-19 because of your overall health or age?

Key Informant Interview Questions

1. We would like to collect some very basic information to help put this feedback into context. If you are willing, can you please share:
    a. The community/organization/workplace/business/industry/sector you represent. You can also just say "community member" if you prefer.
    b. The county or counties that you are connected to. This can be where you live & work as a community member or the counties your organization serves.
2. How have you been impacted by COVID-19?
    a. Do you know anyone who has tested positive for COVID-19?
    b. Do you know anyone who has been very sick or died from COVID-19?
3. Who in your community/organization/workplace/business/industry/sector is most impacted by COVID-19? How are they impacted?
4. How worried are you about getting COVID-19?
    a. How worried are you about someone in your community/organization/workplace/business/industry/sector getting sick with COVID-19?
5. What are the best ways to stop COVID-19 from spreading?
6. Washington State could have a vaccine for COVID-19 in the next year. What have you been hearing about the vaccine in your community/sector/etc.? What are people saying in terms of looking forward to it or being concerned about it?
    a. How are <u>you</u> feeling about the vaccines?
    b. Do you think you will want to get the COVID-19 vaccine?
7. When would you want to get the vaccine? Right when it is available for you, or some other time?
    a. What would make you/your community/sector/etc. more comfortable with the vaccine?
    b. What do you need from the Washington State Department of Health to have more trust and confidence in the vaccine?
    c. What could the Department of Health do that might cause you/your community/sector/etc. to be <u>MORE</u> concerned when we begin promoting it and distributing it?
    d. Is there someone in your life who you trust enough to follow their suggestion to get the COVID-19 vaccine? Who would that be for you?
8. What barriers may people within your community/organization/workplace face to getting the vaccine?
9. Do you have any fears about the COVID-19 vaccine? What are your fears?
10. What do you want to know about the COVID-19 vaccine?
    a. What is the best way to share information like this with you?
    b. Who do you trust for information about the COVID-19 vaccine?
11. Until there is enough vaccine for all people, we will have to make difficult decisions about who should be offered the vaccine first. What should we think about when making these decisions?
12. This is a framework for prioritizing and allocating COVID-19 vaccine that was created by the National Academies of Medicine. The most current recommendations are to start with high risk health workers and first responders. And then offer vaccine to people with two or more health conditions that put them at higher risk for COVID-19 and older adults living in shared housing. Once there is more vaccine, Phase 2 includes teachers, school staff, people in homeless shelters, people with disabilities in shared housing, people who are detained & incarcerated, and people who work in essential businesses and are at high-risk for COVID-19.

a. Do you agree with these initial priorities?
b. Where do you see yourself/your community/business/sector/etc.? Do you agree with how yourself/your community/business/sector/etc. is prioritized?
c. Some of these groups are actually quite large and we may have to prioritize within them. One of the things we're looking at is what puts someone at a higher risk for getting or spreading COVID-19 within each of these groups. Thinking about your community/business/sector/etc. what are some of those factors that could put a certain person at higher risk?
d. What impact would it have on the community you serve/your customers/your business operations/etc. if someone got sick with COVID-19?
e. What else do you want us to know or consider?

13. If you could protect three people in your life from getting COVID-19, who would you protect and why?

Appendix G: Citations

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